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ABSTRACT

The purpose of this publication is to review manpower issues in the field of mental health, identifying their importance and initiating discussion about their resolution. Directed to an audience of manpower development specialists, several types of material are presented beginning with a brief background including a synthesis of recent literature about manpower as it pertains to mental health. The succeeding chapters present a series of "manpower incidents" drawn from experiences of state mental health staff which are included to give concrete examples of manpower issues and activities. Following chapter 1, on background, chapter 2 includes a description of the system and scope of manpower development and a comparison of supply/demand models. Chapter 3 further explores the uses of manpower development, and chapter 4 explains the functions, roles, staffing, and organization of a state mental health manpower program. Chapter 5 presents a rationale and suggestions for developing a manpower program. Appended are definitions of terms and a list of the various elements involved in manpower development. (FP)

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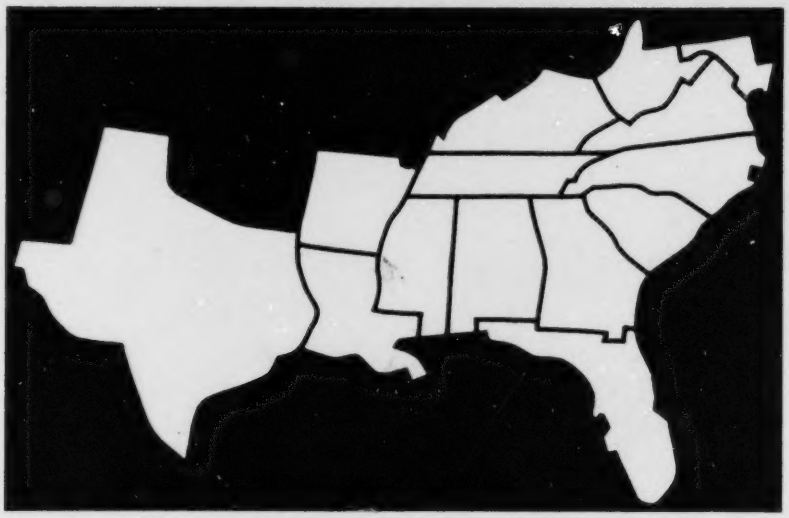
CONCEPTS OF STATE MENTAL HEALTH MANPOWER DEVELOPMENT



Southern Regional Education Board

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TABLE OF CONTENTS

Foreword v

Preface vii

Chapter

1. Background. 1

2. What is Manpower Development? 11

3. Uses of a Manpower Development Program. 33

4. Functions of a State Manpower Program 55

5. A Manpower Development Program. 77

References. 82

Appendix:

Contributors to the Publication 87

Definitions of Manpower Terms 89

Elements of Manpower Development. 93

FOREWORD

Working through its Commission on Mental Health and Human Services, the Southern Regional Education Board (SREB) secured state support to initiate a project in the "new" area of manpower development. In July, 1977 SREB received a grant (No. 1T21-MH-14775) from the Vestermark Center, National Institute of Mental Health (NIMH) for the purpose of implementing a regional approach to assist 14 Southern states in developing their ability to initiate manpower policy development and planning. Since that time the newly formed Center for State Mental Health Manpower Development has assumed most of the responsibilities of the Vestermark Center.

The project's first efforts have been directed at mapping the territory of manpower development. This document is the initial output from these activities and, as such, it represents the ideas and concepts of a group of individuals involved with manpower development in their states. These individuals were designated by their state mental health or mental retardation directors as liaison persons to the SREB project. Their first task was to grapple with the issues inherent in the question "What is mental health manpower development?"

The primary strategy used to answer that question was to utilize the experience and talents of the liaison persons themselves. Each member of a group of representatives from each state contributed thoughts, insights, and

information regarding the relationship between services and manpower. In the process we learned from each other about the concepts of state mental health manpower development. We would like to thank the members of this group, who are listed in the Appendix, for their interest and industry in the project. However, they are not responsible for our interpretation of their ideas. We plan to follow this initial publication with other guideline documents which will focus more specifically on the issues identified herein.

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PREFACE

The purpose of this publication is to call attention to the manpower issues in the field of mental health, to identify their importance, and to initiate a discussion about their resolution. While the achievement of a "resolution" of mental health manpower issues is beyond the scope of this document, and possibly the state of the art at this time, we want to emphasize that some steps can be taken to lessen manpower problems, even if they can't be made to disappear. In an industry as labor intensive as mental health, the primary resource at the manager's disposal is the people who work to achieve the organization's goals and deliver its services. Effective and efficient management of that resource is critical to the survival of the organization and is a major responsibility of the manager.

This publication is being written for a primary audience of mental health program directors and other mental health staff with responsibility for planning manpower programs, for analyzing manpower problems, and for implementing the use of manpower. The latter are called "manpower development specialists" for convenience. A secondary, but important, audience is composed of persons involved in personnel administration, state higher education commissions, state regulatory boards, state legislatures, and the like. The activities and decisions of these latter groups have a powerful impact on the supply, distribution, and use of mental health manpower. While the publication will attempt to identify the various pieces of the total manpower system, we have chosen to focus on the organized state mental health program. The reasons for this are:

- The states are the basic socio-political units which are faced with manpower issues and have both the power and responsibility to do something about them;
- The state mental health program director is in a key position to influence state resources and make decisions about programs;
- The state mental health program is relatively easily identified, although each state is unique in terms of its historical precedent, organization, and political context;
- The state mental health program director is responsible for the delivery of a significant amount of mental health services and employs a significant number of individuals to do it.

Although we shall focus on the state mental health programs, we want to emphasize that manpower development involves more organizations and actors than the state mental health agency itself. One barrier to the implementation of an active manpower development program is the difficulty of conceptualizing the manpower "system." All of the pieces of the system are not currently organized to achieve an agreed-upon goal. A second difficulty is the perceived uncertainty of the relationship between the daily crises with which a mental health director must cope and "manpower development." A program manager must see that attention to manpower will help him/her solve problems.

It is the intent of this publication to present concepts of manpower development clearly enough for the reader to achieve an overview of the issues. It is also our intent to provide illustrations of the connection between manpower development and organization and service delivery programs.

It is hoped that this publication can be a primer on "state manpower

development." It is not our intent to prescribe specific tasks and/or manpower models but, rather, to stimulate some serious thinking about them. Hopefully, the publication will be used as a tool to open further discussion.

The publication presents several types of material. First is a synthesis of recent literature about manpower which seems pertinent to mental health. The purpose is to draw a big picture of the context within which specific manpower issues emerge. Second, a series of "manpower incidents" are inserted in the text to give concrete examples of manpower issues or activities that have actually occured. These incidents were drawn from the experiences of state mental health staff. Third, there are some suggestions about the roles, functions, staffing, and organization of a state mental health manpower program which will put some flesh on the bones of the conceptual manpower skeleton. Fourth, the Appendix contains some definitions of manpower development terms to provide a common language with which to discuss the issues.

Chapter I

BACKGROUND

Introduction

The word "manpower" appears to have an intuitive and relatively simple meaning. It has most often been used to refer to the number of persons who are available to perform certain jobs. For many years the Department of Labor has collected and reported data about employment and the various kinds of manpower needed in certain sectors of the economy; the high (or low) cost of manpower; the manpower strength of the military; the manpower supply in certain categories; the need to shift manpower from one location to another, etc.

As recently as 1973, when Congress established a National Commission for Manpower Policy, it was alleged that a well-defined national manpower program did not exist. The Commission was charged to "identify the manpower goals and needs of the nation" and to assess the degree to which various federal programs constituted "a consistent, integrated and coordinated approach to meeting such needs and achieving such goals."[1] One primary objective of the Commission was "to move employment and manpower from their status as residual matters to be dealt with as problems arise to that of a policy area deserving primary consideration."[2] (Emphasis added.)

The basic purposes of a national manpower policy were stated as:

- To achieve the development of the nation's human resources;
- To provide equality in employment opportunities;
- To achieve "full employment.[3]

In this context the development of manpower policies and programs can be seen as one of the primary functions of government. The development of manpower policies and programs is also one of the primary functions of the management of any organization. The manager of a service agency should be concerned about having the "right" people with the "right" skills at the "right" place at the "right" time doing the "right" thing to get the job done.

Health and Mental Health

The need to develop manpower policies and to coordinate manpower programs is also present in the area of health care and mental health care. Note the following trends which call attention to the size, scope and costs of manpower in the health and mental health areas:

- Total national health expenditures were $118.5 billion in 1975 with 60 percent of these expenditures for private services.[4]
- The direct costs of mental health services are estimated to have been $17 billion in 1976.[5]
- Employment in the health sector expanded by almost 65 percent from 1960 to 1970 so that one out of every eight new jobs created in that time period was in health care.[4]
- Each new physician entering practice creates from $150,000 to $350,000 in additional health care expenditures annually.[6]
- The federal government budgeted approximately $1.5 billion for health training and education in 1974 with about $44 million for mental health professionals, excluding nursing, research, and paraprofessional personnel.[7]

- In 1976 there were approximately 4.5 million persons (5.5 percent of the total labor force) employed in the health care industry.[7]

- The mental health industry provides employment for more than 500,000 persons in 4,500 organizations.[8]

- In January, 1976, state and county mental health hospitals employed 226,213 persons, 40 percent of whom were para-professional staff. Overall, 54 percent of the physicians employed were foreign medical graduates. There were an additional full-time 48,466 persons, or the equivalent employed, in 526 community mental health centers.[5]

If the persons involved in delivering other social services were included in the data above, the totals would be significantly larger. Because much of the social and mental health services are delivered by public agencies at the local and state level, managers of such agencies have a vital stake in the potential use or misuse of manpower. The recent passage of Proposition 13 in California (June, 1978) has underscored the relationship between the perceptions of the local citizenry regarding the use of public funds, the delivery of services and the management of manpower.

Federal Initiatives

Several pieces of recent federal legislation have had direct impact on state mental health programs and have raised new manpower issues. The National Health Planning and Resources Development Act (PL 93-641) has established a network of health planning agencies with review and approval authority over local mental health programs. One of the criteria for the review of service programs is the availability of manpower resources and the analysis of the alternative uses of those resources to meet community health needs. State and local mental health programs are in competition with

other programs which use similar manpower to provide services. The simple solution of more manpower for everybody will not meet the cost containment guidelines which are also required in the review of programs.

The Community Mental Health Center Amendments of 1975 (PL 94-63) require mental health organizations to have an "adequate supply of appropriately trained mental health personnel" to assure the delivery of required services. Consequently, the regulations request that the state mental health plan include a summary of the state's manpower capabilities and a plan to develop and maintain an adequate supply of personnel.

The Health Professions Educational Assistance Act of 1976 (PL 94-484) has had immediate and direct implications on the manpower supply of those state agencies which employ large numbers of foreign medical graduates in their state hospital systems. The Act alters the funding for schools training health professionals, limits the use of foreign medical graduates, and establishes rules for payback provisions for graduates who have received federal assistance in securing their professional training. It also sets the conditions under which a medical school may receive federal funds. These conditions are such that they do not encourage training of psychiatrists, but do encourage training of primary practitioners in medicine, osteopathy, and dentistry. At the same time, the number of American medical graduates entering psychiatric training is decreasing.

The Education of All Handicapped Children Act (PL 94-142) is intended to assure an education to all handicapped children -- including those with emotional disturbances, learning disabilities, and other mental handicaps --

that will be geared to their special needs. The Act applies to all states which utilize federal funds to support public education. While the legislation requires that certain services be available to diagnose, evaluate, and counsel handicapped children and their parents, there is no indication of who is to provide the services. The services are to be given so that the child may be educated and they are to be made available at no cost to the parents. In addition to the question of whether the public education system or public mental health system will supply the services, there is the issue of where the manpower comes from to perform the work.

This brief summary of federal legislation is meant to indicate the impact on state service programs of federal policies which have specific implications for mental health manpower. While federal and state governments have long been concerned about the overall size of the work force, employment, and income levels, current legislation frequently emphasizes the activities to be performed by federally supported programs and focuses on specific types of manpower. The Health Professions Assistance Act of 1963 for the first time authorized direct support for the teaching activities related to producing health professionals. The National Institute of Mental Health (NIMH) has supported, over a longer period of time, the basic training of various disciplines judged essential to mental health service programs. Support for training of various psychiatrists, social workers, psychologists, nurses, and paraprofessional service workers has increased the numbers of such persons in the work force. However, these training programs have not assured the availability of quality mental health care at reasonable cost to some

significant segments of the nation's population.[5] Therefore, a reexamination of mental health training programs was instituted by NIMH in 1974-1975 to identify manpower issues and to plan a redirection of federal training efforts if such was required. At issue was the exploration of ways to plan for mental health disciplines. More recently, the President's Commission on Mental Health[5] reported on the need to improve the distribution of mental health workers to areas currently unserved or underserved, to increase the number of minority mental health personnel to serve bilingual/bicultural groups, and to expand the number of mental health specialists prepared to meet the needs of special groups (e.g., children, elderly).

State Initiatives

In addition to, or in combination with, federal legislation, the various states are dealing with manpower issues of several types. These issues may be of more concern to states than federal legislation per se as state officials are held directly responsible to do something about them. For example:

- The recruitment, utilization and retention of mental health personnel (particularly psychiatrists) for public services in state hospitals and rural areas;
- Personnel issues relative to the deinstitutionalization of state hospital patients, including the transfer of staff (plus benefits, seniority, union rights) to community programs, and the retention of appropriate personnel to meet the needs of a changed patient population;
- The productivity of existing staff in community mental health centers (CMHCs) in the light of diminishing federal funds and the need to produce adequate revenues;
- The training of clinical supervisors and other middle management staff of public agencies in areas of program evaluation, budgeting, program administration, and program development;

- The recruitment of minority mental health workers to treat minority populations and to sensitize agencies to minority needs;
- The development of personnel administration procedures to adequately conform to affirmative action requirements, career ladders, job selection and promotion criteria;
- The design of professional training programs to make them more compatible with the needs of the public service system.

These issues represent the problems that state-level officials struggle with most often. Any particular issue may be the focus of current concern; all of them are ongoing and require constant attention.

Mental Health Manpower Development Programs

Although no clearly articulated solutions for most mental health manpower issues have emerged, there have been some suggested directions. In 1962, Kentucky created a Mental Health Manpower Commission by an executive order of the governor, with initial funding support from NIMH. The Commission was charged with studying mental health manpower problems, recommending policies and developing training programs and resources to deal with identified issues. In 1977 it completed its 15th year (as a private, non-profit corporation) with a long list of studies and action programs related to improving delivery of human services through manpower development.

During this time they have studied and made recommendations on a variety of topics including:

- The state psychiatric residency training plan;
- The establishment of a day care center for the children of working mothers at a state hospital;

- A program to reduce turnover in psychiatric aides;
- A program to teach English to foreign physicians.

Starting in 1973, the Vestermark Center (Division of Manpower and Training, NIMH) funded five pilot state projects for the purpose of stimulating the planning for and development of mental health manpower. The projects resulted from negotiations between each state and NIMH and were designed to work directly with state mental health agencies to explore more effective ways of increasing manpower capacity. The projects focused on different issues congruent with each state's needs, such as:

- A model for statewide assessment of manpower needs;
- An identification of catchment area service problems from which a staffing pattern was derived;
- Design of a system-wide method for manpower development and utilization;
- Initial implementation of priority manpower programs based on findings of a multi-agency task force;
- Development of a manpower plan based on service needs generated by deinstitutionalization.

As part of NIMH's own effort to evaluate the impact of its manpower and training activities, in 1975 it established a work group as part of the Services Manpower Task Force. The charge to the work group was to examine the role of states in the development of mental health services manpower and to suggest activities that would strengthen the state's ability to plan more effectively in the manpower arena. (The work group's recommendations were

subsequently incorporated into the Alcohol, Drug Abuse, and Mental Health Administration's (ADAMHA) Forward Plan FY 1978-1982.) The group concluded that mental health manpower issues must be seen in a larger "systems" perspective in order to include all the important factors which determine the supply, distribution, and utilization of manpower. The phrase manpower development was used to describe the range of activities related to the development and utilization of personnel. Manpower development was seen as more than training or personnel recruitment or professional education or job assignment. Rather, it required a comprehensive view of the pieces of the manpower puzzle, their interrelationships, and the purposes for which manpower is utilized.

Subsequently, the Division of Manpower and Training initiated a grant program (July, 1977) for a State Manpower Development Program which focused on enhancing the capacity of the state to address the range of activities important to mental health manpower development in a comprehensive manner. The successful grant applicants began a variety of activities relevant to state manpower development in July, 1978. This program explicitly recognized the state as the critical level for action in mental health manpower development.

Chapter II

WHAT IS MANPOWER DEVELOPMENT?

Definitions

A dictionary definition of "manpower" is (a) the power available or supplied by the physical effort of man; (b) the strength of a nation, community, industry, etc., as expressed in terms of available persons.[9] This is a straightforward definition of what people mean when talking about manpower. The second part of the definition emphasizes the number of persons available and conforms to the most frequent interpretation of the term "manpower." The first part emphasizes the power available from the work of a person or group of people. This meaning is easy to imagine when one is concerned with physical effort. It is less easy (but not impossible) to imagine when one thinks in terms of mental health activity or of the services derived from non-physical work.

The Services Manpower Task Force recognized that "different words have different meanings to different people" and their report included a series of definitions to clarify their recommendations about manpower development.[10] This set of definitions can be found in the Appendix, but a few are noted here as the basis for further discussion:

> Manpower: The capacity available or required in terms of personnel to deliver mental health services.
>
> Manpower Development: The sum total of activities designed or employed to increase the numbers and effectiveness of personnel engaged in delivery of mental health services to clients or communities.

Manpower Development Program: An organized and systematic series of activities designed to increase the numbers and effectiveness of mental health workers for the delivery of mental health services to clients and communities.

These manpower definitions are intended to combine both the "power" and "number" aspects of the dictionary definition and direct attention to the "capacity" available to delivery services. The Task Force recommended that NIMH initiate programs which would focus on "state capacity building" in the manpower arena. In this case, state capacity building referred to "creating or improving the ability of a state to carry out a specific program or activity."

While these definitions and guidelines begin to give some substance to the concept of manpower development, they do not describe what "capacities" or "capabilities" need to be developed to perform the activities described by the Task Force. It may be easier for the reader to think about the "capability" or "competency" or "power" required to perform manpower functions than to think in terms of "capacity." The intent of the Task Force was to focus attention on the variety of activities which a state mental health program may engage in for increasing the numbers and effectiveness of mental health workers in that state.

As noted earlier, we most often think of manpower in terms of the number of persons in a category -- e.g., the size of a military unit, number of unemployed, number of medical students. If we think of manpower in terms of the "power" available to do something, a different view of manpower appears. The work force becomes a resource pool of skills and abilities rather than

simply people classified by discipline or job description. The operation of a specific type of service requires staff with a certain mix of skills and abilities. If we know what skills exist in the work force, our job becomes one of organizing and deploying persons to best perform the tasks based on the skills needed. If the skills are not present in the work force, we must recruit for the skills required or develop the skills through a training program.

In the past, manpower development was most frequently seen as a training activity (e.g., orientation of new workers, in-service training, continuing education) or as a personnel administration activity (e.g., job classification position specifications, employee recruitment and selection). When manpower development is viewed as activities designed to increase "the numbers and effectiveness of mental health workers," a broader range of considerations is added to training and personnel functions. Some of these considerations are the improvement of manpower distribution and utilization; the development of more effective staffing patterns; the creation of more productive working environments, and the lessening of administrative barriers that hinder the flexible use of personnel.

This broader definition of manpower development pinpoints some gaps in our knowledge. For example, to match the capabilities of the work force with the tasks to be performed to deliver a planned set of services requires knowledge about what human resources exist and what skills are required. Most agencies do not have sufficient data about the skills and abilities of their staff. This view also calls attention to our inadequate knowledge of the relationship between effective services and the skills required to

provide them, and between the skills required and the type of manpower needed. It also directs attention to a concern with what people can do -- their capabilities or competencies -- rather than with their titles or professional degrees. If a program manager has better information about the competencies of the work force and a better understanding of the relationship between services and skills needed, he/she can (a) reorganize staff to match their competencies to tasks, (b) evaluate existing or proposed staffing patterns for their effectiveness, (c) develop productivity measures for staff, or (d) focus on working conditions and employee incentives that will enhance staff functioning and reduce staff turnover. Thus, the manager not only has a broader range of issues with which to be concerned, but also has a broader range of points for intervention into the "system."

The word "competence" is currently used in a variety of ways. One use is to refer to the overall ability of a worker to perform a given job or role satisfactorily. Nationwide there is a great public interest in assuring the continued competence of health and mental health professionals to deliver services. A second use of "competence" is more specific. "Competency" and "competencies" also refer to the ability to carry out a specific function or activity which may be part of a job. Many educational institutions are developing performance-based curricula to teach certain "competencies." In a similar manner, employing institutions are developing competency-based job evaluations to document the workers' ability to perform a given activity. In the comments above we are using "competencies" in the latter, more specific sense. A collection of competencies may provide the competence to satisfy a certain role, e.g., a program manager.

The Manpower "System"

A major problem encountered in discussions about manpower development is an uncertainty of what the manpower "system" is. If a "system" is a set of interrelated parts designed to accomplish a given objective, no one designed the existing manpower "system." The existing "system" is a natural system in the sense that its component parts evolved separately to serve various purposes and objectives. The major parts of the "system" -- e.g., professional schools, state licensing boards, personnel systems, service delivery agencies -- seem to have developed in isolation from each other.

An illustration of potential isolation and conflict among the parts of the "system" can sometimes be found in the intent and implementation of state legislation. In recognition of the need to protect the public welfare, legislatures have established basic licensing requirements for certain occupations. Professional associations have also established certification requirements for their members. The licensing and certification requirements may or may not be congruent. Although the purpose is to protect the public by assuring the "competency" of the practitioners, the certification requirements may not contain all the "competencies" needed in the various service delivery settings. Also, official job descriptions frequently incorporate certification requirements for a person to be eligible for employment, and state personnel commissions, which write the regulations for state employees and classify positions, have been deliberately set up by legislative action in positions isolated from outside political and administrative pressures. Again, the purpose was to protect the public and public employees by assuring

MANPOWER INCIDENT

Background

A state mental retardation program faced the problem of dealing with changes in its service goals. The staff was used to provide custodial care for patients. The program was suddenly mandated with providing education and training services to its patients as a result of new treatment philosophies and technology. The existing staff lacked the skills, information base, and value orientation needed to handle the new job expectations and, as a result, those expectations were not met.

Analysis

It became apparent that either a new staff with the proper qualifications would have to be hired or the existing staff retrained. Because of time, cost, administrative procedures, and the uncertainty of the outcome, neither alternative was considered desirable.

Action and Results

A decision was finally made to create a new career ladder consisting of specialists in behavior modification. These positions were placed at a supervisory level and were designed to provide the education, training, and therapeutic programming skills which the traditional staff could not provide. The proposal, however, was not fully implemented by the administration which feared the proliferation of job titles, higher pay grades, and a more complex table of organization. One result of the incomplete implementation was that, because of existing personnel procedures, these new positions were often used as a "dumping ground" for undesirable staff from other departments. Another result was a "we/they" split in the staff. The traditional staff felt they were not getting paid to "train kids." At the same time, the staff transferred from other departments did not have the skills for the job.

MANPOWER INCIDENT

Background

A department of mental health had two major policies regarding personnel: 1) positions for various kinds of workers were assigned to institutions regardless of physical arrangements, age of facilities, kinds of patients, etc.; 2) each institution director was allowed discretion in how he used these positions. These policies led to a difficult situation at one state school where psychiatric attendants were assigned to duties, such as housekeeper, switchboard and elevator operator or dietary worker. At the same time, there were complaints that the wards were not adequately staffed, although the official rosters showed the required number of staff.

Analysis

An on-site study by the mental health and civil service offices revealed that the attendants were usually assigned to other duties to deal with temporary crises but then were never returned to their original duties. The study also found that some services were undermanned due to the physical arrangement of the facility, and needed more staff than had been allocated by the office of mental health. When a "crisis" arose, the service did not have enough staff to handle the situation and personnel were "temporarily" drawn from other areas.

Action and Results

The practice of reassigning staff was discontinued and persons who had been loaned to other services were returned to their original positions. However, the basic issues of determining real staffing needs based on the special requirements of each institution and of limiting the director's power to make arbitrary staff reassignments were not resolved. Similar staffing problems continued until a class-action suit against one institution resulted.

equity in personnel administration. However, this combination of events has sometimes produced a bureaucratic, nonflexible system relative to recruiting, selecting, and utilizing personnel. At this time there is need for more flexibility in the use of health and mental health manpower resources to plan for more effective services and to contain costs. As one analysis of health policy noted:[4]

> "Health sector jobs have few promotion possibilities because of the rigid manner in which health occupations are controlled. The health industry is credential-bound. As growth in hospital employment decreases, it will be necessary to intervene to alter the credentialing and certification process."

As no single person or institution has control of all parts of the "system," such interventions will require coordination among legislatures, professional societies, personnel administration, and the service system.

After assessing five pilot state manpower projects, Wayne Kimmel comments:[11]

> State officials are simply not in the habit of thinking in manpower terms as opposed to personnel or training terms. Indeed, since most state agencies are responsible for their own bureaucracies and for the operation of large institutions, "personnel and training" issues are a central part of their administrative responsibilities. To take a "big picture" or "systems" view is intellectually difficult and there are no sustained incentives to do it. (Emphasis added.)

The next chapter of the publication will address some of the incentives for attempting a "systems" view. The section below will present a number of ways of looking at manpower systems. These are not mutually exclusive

perspectives, but simply different ways of trying to organize the naturally occuring parts of the manpower development system.

Scope of Manpower Development

The Services Manpower Task Force categorized manpower development activities under four major headings, each with several subheadings. (A more complete description of each element will be found in the Appendix.) The purpose here is to present an initial list of the various aspects of manpower development that will identify the broad array of activities which may be included. The major headings may be seen as four major elements of the "system," each of which is relatively self-contained.

Elements of Manpower Development

I. Mental Health Manpower Planning and Evaluation

- A. Manpower Data Systems
- B. Manpower Policy Development
- C. Manpower Needs Assessment and Projections
- D. Manpower Program Planning
- E. Manpower Program Evaluation

II. Mental Health Manpower Administration

- A. Recruitment of Manpower
- B. Distribution of Manpower
- C. Utilization of Manpower
- D. Career Systems and Retention of Manpower
- E. Minority Issues in Manpower

III. Mental Health Manpower Training

- A. Education Planning
- B. Preservice Professional and Paraprofessional Education
- C. Continuing Education
- D. Experimental Education
- E. Funding of Education Programs

IV. Regulations and Sanctions Affecting Mental Health Manpower

A. Licensure and Certification
B. Standards Regarding Manpower
C. Judicial Activities
D. Unions
E. Legislatures and Regulations
F. Payment Patterns for Mental Health Services
G. Personnel Policies and Practices
H. Status Considerations

While the Task Force's identification of the major elements is helpful, the descriptions of the activities involved tend to be nominal; that is, they name the element but do not specify a course of action to be followed to assure that the function involved in the element is carried out effectively. As indicated elsewhere,[12] the list also tends to mix functions, issues and the major actors in the manpower drama. However, it is a useful beginning in identifying the factors which influence manpower for services and in sketching the outlines of the manpower development domain.

Major Actors

A project centered at Johns Hopkins University ("States and University Mental Health Manpower Consortium") is a collaborative program among the states of Delaware, Maryland, West Virginia, Virginia, Pennsylvania, New Jersey, the District of Columbia, and Johns Hopkins University to explore manpower issues and to establish a process to identify manpower problems. The ultimate goal of the project is to create a curriculum to train "manpower planning and development specialists." As the project is concerned with the process of identifying manpower problems, a process model of manpower in mental health has been constructed. The major components of this model[13]

are viewed as the major processes involved in manpower development. Within each process area there are persons or agencies (major actors) which influence the ultimate supply and use of mental health workers. The major components of the model are as follows:

I. Production of Manpower

A. Potential Manpower Pool

B. Manpower Producers
1. Colleges and Universities
2. Community Colleges
3. Vocational Schools
4. Professional Schools
5. Other

II. Utilization of Manpower

A. Planners for Manpower
1. Mental Health Service Planners
2. Organizers of Services
3. Authorizers of Jobs and Positions
4. Classifiers of Positions

B. Implementers of Manpower Plan
1. On-the-job Trainers
2. Recruiters of Personnel
3. Performance Evaluators

III. Regulation of Manpower

A. Professional Societies
B. Accrediting Organizations
C. State Licensing Boards
D. Legislatures
E. Judiciary
F. Executive and Administrative Branches of Government
G. Health Planning Agencies
H. Unions
I. Third-party Payers
J. Mental Health Boards

Although this is an oversimplification of the model, it does serve to focus attention on the large number of individuals and agencies who play a role in the various process essential in developing manpower. Each actor may establish policies and procedures which help or hinder the availability and utilization of manpower resources. Many of these actors may not be aware of the influence of their decisions on the major processes of the "system" -- i.e., production, utilization, and regulation. This simplified inventory of actors allows for initial recognition of relationships between otherwise disparate individuals and organizations. The model emphasizes the degree of cooperation and coordination required among these actors for mental health services to be delivered effectively. The model also identifies those actors who must be involved in the resolution of specific problems.

Social Systems

Eli Ginzberg, currently chairman of the National Commission for Manpower Policy, recently examined manpower from a national perspective.[14] He believes that manpower can be analyzed only within the four major systems of a society. The first system is the value structure of that society which determines which goals are judged important to establish and how resources will be allocated to achieve them, e.g., each person should have equal access to opportunity.

The second major system is government, which is the vehicle for collective action to achieve those goals derived from the value structure. In a pluralistic society it is not always easy to establish a single set of goals. However, the government does set policies and establish programs which are aimed at achieving valued ends. Government programs obviously have an effect

on the level of employment and on the utilization of various types and levels of workers through regulations, payment patterns, and funding initiatives.

The third major system is the economy which provides the resources for the production of goods and services and, consequently, generates employment opportunities. The level of the economy is closely associated with the effective and efficient use of manpower which, in turn, is dependent on the competencies and productivity of the work force.

The fourth major system is composed of the manpower institutions -- the nuclear family, the formal educational system, and the employing organizations. These institutions are responsible for the socialization of the individual, the development of needed skills, and the provision of the conditions in which people will use their skills. The work environment should promote the effectiveness and efficiency of the work force, and contribute to further skill development which then generates more opportunities and economic growth.

In Ginzberg's view, the manpower strategy of most organizations is based on a marketplace model. This model holds that the worker and agency interact significantly only at the time of employment; that the worker is compensated only on the basis of productivity and that work only has utility for the worker in terms of that compensation. Ginzberg questions the appropriateness of this model and chooses, instead, to view work as a social activity which yields direct satisfaction to the worker. His approach assumes that workers desire a continuing "affiliation" with the employing organization beyond the initial interactions. They want to increase their repertoire of skills and

fulfill psychological needs in work. In addition, workers desire sufficient compensation to maintain an appropriate quality of life.

In this context, a manpower policy is a statement of the "actions that a society can take to increase the opportunities available to its members to develop and utilize their skills."[14] That policy should be designed to provide the employee with the opportunity for developmental experiences, employment opportunities, the chance to develop additional skills, and equity.

While Ginzberg's approach is stated in macro terms, he is persuasive in placing manpower utilization and manpower development at the center of much social, governmental and economic activity. This conceptualization calls attention to the fact that a manpower policy statement is a blend of values, goals, and actions to be taken. These actions include the issues of the motivation to work, productivity, the role of management and training.

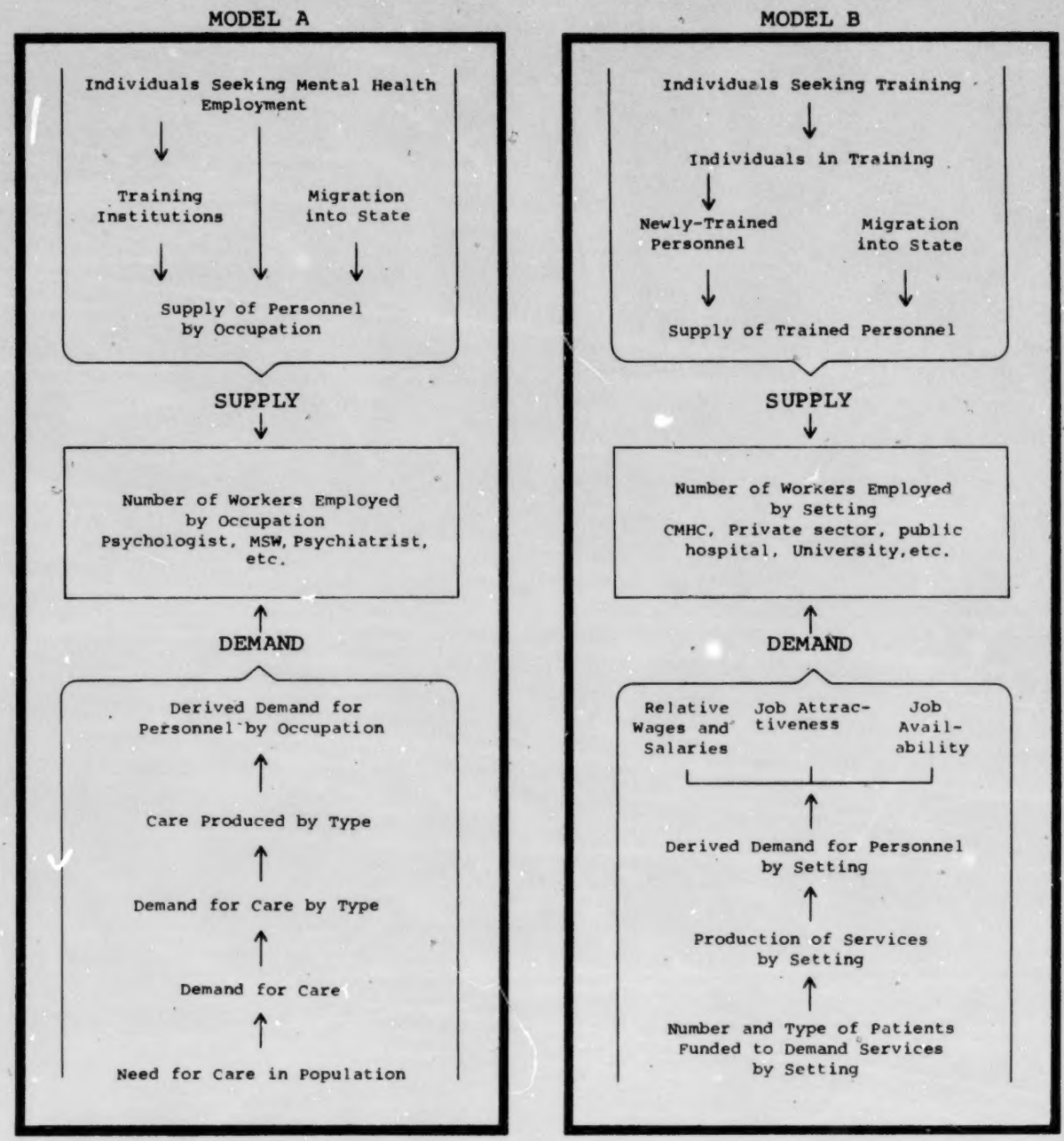
Supply and Demand

Another approach to describing the manpower development "system" is to view it in terms of the supply and demand for personnel. Economists analyze labor markets in order to understand the effects of various factors which determine the numbers and types of workers employed and their distribution. In the course of fulfilling a NIMH contract, Abt Associates, Inc. constructed several frameworks for describing the supply and demand of mental health workers.[15,16,17] Their purpose was to identify the major factors of supply and demand to identify points where state level mental health policy decisions could influence the match between the number and types of workers available and manpower needed in the service system.

Figure 1 is a simplification and modification of two of the supply/demand models developed. They are presented here to illustrate several points. The first is simply to provide examples of what a supply/demand model might look like. The second is to call attention to the differences in the two models. A major difference in the models is the focus on the number of persons employed by occupation (Model A) or by setting (Model B). If one wished to acquire information about the current status of manpower, each model suggests the collection of different primary data, i.e., by occupation or by setting. General knowledge of the number of psychiatrists employed in a state would not tell us the location of the persons employed or what functions they perform. In each case the primary data categories would need to be further elaborated to provide information more useful in describing current manpower supply and distribution. Therefore, the specific supply/demand model utilized needs to be consistent with the questions to be answered.

There is much information that documents the large degree of "substitutability" in mental health staff.[18] "Substitutability" is where one type of worker can do all or some of another worker's job functions. For example, "assessing the mental state of a client" is an activity performed by psychiatrists, psychologists, social workers, and others. "Substitutability" is also present when a nurse who has specialized in adult mental health services can perform many of the tasks required in geriatric services and can, therefore, be used in one job or the other. Again, simply counting the number of psychiatrists, psychologists, social workers, or nurses who are available

Figure 1
MODELS OF MANPOWER SUPPLY AND DEMAND



for employment will not provide an adequate picture of the skills or competencies available to perform the activities required in the service system. It becomes important to select a model which will provide the manpower planner with the "best" picture of the system.

At the same time, we usually categorize manpower supply by the type of preservice training and/or experience acquired by the worker. Training institutions produce manpower by "occupations" not by "settings." Therefore, knowledge of the length of preservice training and the capacity of institutions to produce graduates provide a basis for estimates of the ease or difficulty of increasing the supply of specific occupations by educational mechanisms. It provides a picture of the "pipeline" for manpower. Also, many positions in the mental health field require that a person have specific educational credentials, and this information is needed as an indicator of supply for those positions.

The third point concerning supply and demand is that manpower requirements are actually "derived" from the type of care providers are willing to produce, not from the "need" for care in the population. If, for whatever reason, providers wish to supply alcohol detoxification services, then the demand is for the type of manpower to staff these services. This assumes that we know the appropriate staffing mix for the services. Model B focuses on the major types of mental health settings in which services are provided. These mental health settings are in competititon with each other for the available supply of personnel. Information on employees by setting, therefore,

provides a usable picture of how manpower is distributed, where it is needed, and which settings are seen as attractive. In this case, the function to be performed by the worker may be more important information than occupation.

The fourth point is that the supply and demand side of the models are not necessarily compatible in the manner in which personnel are characterized. The demand side of the model may generate a demand for manpower by occupation, by setting, by location, by function, by service type, or by client characteristics. We need a better understanding of the relationship between occupational credentials and the attributes required to perform the services. As the objectives and tasks of the service system tend to change more rapidly than training programs and/or credentialing requirements, a disparity is created between the characteristics of supply and demand. However, the awareness of that fact will help bridge the gap and perhaps prevent inappropriate collection of data.

As noted above, Figure 1 is a simplification of the models developed. Omitted here are those points where policy interventions may be made to influence the flow of manpower. For example, increasing "job awareness" can increase the competitive position of one practice setting compared to others. Provision of student stipends can increase the number of persons in training. Cooperation between the operating agencies and training institutions can reduce the sometime serious disparity between supply and demand.

Roles in Manpower Development

The preceding comments illustrate that there are alternative views of the manpower system. There are few common definitions among the several "system" models. Planners of manpower development programs who work at different levels -- national, state, local -- are likely to define the "system" and its components differently because they have different purposes and responsibilities. There are, in fact, multiple factors that affect the supply and utilization of personnel, and this difference of perspective is unavoidable and realistic. Each view of the "system" provides new information about the relationship among the major elements, actors, institutions, and other determinants.

After reviewing five state pilot projects in manpower development, Kimmel recommends, in a report to NIMH, that:

> ...the objective of manpower capacity building should be to accurately identify the alternative roles which a state does or could play in the larger manpower area and to strengthen capacities in those areas.[11]

The roles that a state program could play will further specify what manpower development is. In this context, "role" means a combination of functions carried out to achieve an identified objective.

The objective of the first role, that of problem identifier, is to assist the organization in matching its human resources with its service delivery requirements. This requires examination of the internal operations of the agency, the external environment within which it operates, and the

supply and utilization of personnel. A major output of this role is the identification of current or future service delivery problems in which manpower is a key issue.

A second role is to act as a sensor, gathering information about identified manpower issues. Manpower issues may be categorized in terms of (a) supply, (b) distribution, (c) utilization, and (d) productivity of mental health personnel. A complete description of the status of manpower resources will require some data in each category. The sensor can also identify areas where special studies need to be conducted, e.g., staffing patterns, staff activities, functional job analysis. A major output of this role is the presentation of information resulting from analysis of data about manpower.

A third role, that of manpower planner, is built upon the previous outputs of problem identification and information analysis. The role consists of activities that will delineate specific issues and establish steps which can be taken to deal with them. The major outputs of this role are recommendations for policy decisions by appropriate parties and the development of action plans.

A fourth role, that of facilitator, assists in the implementation of manpower policy decisions. This role includes activities related to making others aware of manpower issues, advocating particular activities, and communicating existing manpower and service plans. The major output of this role is an increase in the "readiness" to bring about the changes called for in the plan.

A fifth role is that of coordinator of the frequently fragmented manpower capabilities of the state mental health programs. Most state mental health programs already have a personnel program, a data gathering and evaluating capability, and training programs. The states also have commissions of higher education, licensing boards, personnel commissions, and health planning agencies. Each of these may be operating in isolation from the others, although each has considerable expertise in its specific area. It is unlikely that they are currently operating in a coordinated manner regarding mental health manpower. The major output of this role is a "linking" of the existing capabilities and/or decision makers around issues of manpower.

Assuming that these five roles are organized and played effectively, the overall output would be the development of a manpower program that would lead to more effective and efficient delivery of services. The roles of evaluator and administrator are assumed to be present as someone needs to organize, coordinate, and oversee the activities implied by the roles. The five roles are intended to identify a set of functions with which to establish a manpower development strategy. The specific role names are arbitrary. Other "roles" may be added to this list, e.g., innovator, experimenter, monitor, trainer, depending on the existing capabilities and structure of the organization. The important focus is the output of the roles and the functions required to produce the output.

Chapter III

USES OF A MANPOWER DEVELOPMENT PROGRAM

The various models of the manpower system -- i.e., elements, actors, supply/demand and roles -- can be used to describe the current status of manpower and to identify the capability of a state to carry out a range of manpower activities. If the distribution of personnel by setting is inadequate, are there existing procedures for increasing the acceptability or attractiveness of the vacant positions? If the supply and distribution of personnel appears adequate, are there procedures for assessing the use of staff to produce the necessary level of services?

Until recently the major emphasis in manpower planning has been on assessing and increasing the supply of workers. This is no longer the case. Currently, there is a great emphasis on the distribution of care providers which results in significant segments of the population without access to services. On the other hand, the factors affecting utilization and productivity of staff have received relatively little attention. However, a program director can influence these factors more directly than the factors in the areas of supply and distribution. Consequently, managerial attention to issues of utilization and productivity of staff may produce improvements in service delivery equal to the addition of more personnel. The nature of mental health services frequently conditions how personnel are used and services produced. The effective use of manpower is a primary variable in providing efficient mental health operations.

Nature of Service Agencies

The most pervasive characteristic of mental health agencies is that they are labor intensive. It is often noted that approximately 80 percent of a mental health budget is invested in staff. It seems self-evident that this investment should be carefully and deliberately managed to produce desired outputs relative to the agency's goals.

While any organization needs to manage its investments efficiently, the fact that the major resources in mental health programs are people makes this a somewhat more difficult task than if the resources were machines, buildings, or inventory. Employees are not standardized; there are various degrees of agreement between individual goals and organized expectations. Staff members are motivated by different incentives. The establishment of a formalized set of operating procedures, personnel regulations, and position descriptions does not assure that staff will act in the prescribed manner. While this may make the manager's job more difficult, it does not lessen the responsibility to effectively organize and direct the work force. Public mental health agencies, along with private industry and business, share a need to manage their manpower as effectively as possible.

Another characteristic of mental health organizations is the elusive nature of the purposes, objectives, and outcomes of their programs. The overall purposes of public programs are frequently mandated by external authorities, such as the legislature, governor, or funding sources. However, specific agency objectives are not easily stated in measurable terms.

Acceptable measures of outcome depend on which one of the several constituencies to whom the agency is accountable is judging the program. The absence of a concrete "bottom line" product or profit margin complicates the assessment of the efficient or effective use of manpower. It also creates a situation in which individual workers may be unsure of how much (or if) they contribute to the accomplishments of the organization. When workers know and can see their contributions to the agency they report greater work satisfaction and demonstrate greater skill development in their jobs. Organizations that generate hard products or profits have criteria against which to examine their use of manpower. When the expected outcomes of an activity are ambiguous, workers do not know how to act to increase the effectiveness or efficiency of their efforts. This is simply another way of saying that mental health (and other human service) organizations need to make their goals and objectives as clear as possible before manpower issues can be adequately analyzed.

Management Practices

One response to the situation of uncertain outcomes and employee uncertainty concerning contributions is to develop a set of regulations for personnel selection, worker behavior, employee evaluation, job performance, promotion, etc. These regulations can easily become institutionalized and rigid, although they provide "clarity." If the strict enforcement of existing regulations, or the development of new ones, will not guarantee that workers will do what they are supposed to do, what other action can the manager take?

MANPOWER INCIDENT

Background

We wished to upgrade two types of workers in the state hospitals -- the psychiatric aides and clerical workers interested in direct service positions. With grant support from the National Institute of Mental Health, we established A.A. degree Human Service Worker programs combining community colleges and state hospital training programs. However, we found we had no authorized personnel position in which to place these graduates.

Analysis

In the past we dealt with personnel to establish a specific position one case at a time. In this instance, however, our strategy was to work with personnel to set up a whole sequence of work categories and job descriptions for the class of Human Service Workers.

Action and Results

The strategy of displaying the whole class of workers with all the possible positions seems to work better with personnel. However, another problem has developed. The Human Service Worker now acts like junior social workers or consultants rather than "super" psychiatric aides. Since many of our best people went into the program, the less ambitious and less skilled staff are left with the daily responsibilities of the psychiatric aides.

MANPOWER INCIDENT

Background

The Department of Mental Retardation has experienced a tremendous growth in numbers of personnel employed over the past several years. Positions have been added to reduce client/employee ratios and to staff new or renovated facilities. It became apparent that there was no particular system for determining staffing ratios by individual components of the service delivery system. The only ratios available were aggregate figures for an entire residential center. Therefore, the efficiency of staff deployment could not be readily identified.

Analysis

A manpower survey was conducted by the Central Office in each of the four regions in the state. A format for the survey was designed to reflect the staffing ratios in three categories of employees within each region. The three categories were Direct Care, Program Support, and Administration and Physical Plant Support. The format allowed for client/employee comparisons.

Action and Results

It was determined from the survey that there were inconsistencies within the individual regions and among the regions in staffing patterns. The survey pointed up an underutilization of manpower in both the physical plant sector and in the infirmaries. The average daily attendance in the infirmaries was substantially below the potential and, consequently, the nursing staffing ratios were out of line. The infirmary beds in one center have been cut from 22 to 11 with the recertification of the withdrawn beds to ICF/MR as a result of the survey.

A frequent answer is "training." The assumption is that if staff know what to do, they will do it. Mager,[19] in one of a series of useful books about training and education, provides several illustrations to make the point that all performance deficits are not training needs. The same point is made in a survey of recent literature about worker productivity.[20] Various types of training programs were found to produce positive results in terms of worker productivity, and other training programs were found not to have the desired effects. Although training is a common technique used to change behavior, the authors conclude that "training may fail when tried as a remedy for the wrong disease." The same literature survey suggested that several other approaches also show results in improving performance, such as:

- Identifying for the worker what effective behavior is and providing the opportunity to exhibit it;
- Setting clear and feasible performance goals for the worker;
- Redesigning jobs, taking into account various types of organizational structures, the nature of the work, and worker characteristics;
- Providing financial compensation, or other rewards, which are contingent upon performance.

The intent here is to emphasize that, although personnel actions and training are a commonly perceived part of the administrative responsibility of managers, there are additional actions which are also part of the manager's responsibility and are included in manpower development. In industry and business these sets of action are frequently referred to by the phrase "human resource development" (HRD). For example, it is generally agreed

that high employee morale does not guarantee results, there are numerous reports of increases in productivity through job enrichment, job restructuring, participatory problem-solving, delegation of authority, and other efforts to involve the worker in task achievement. If manpower development is seen as a broad set of activities designed to "increase the numbers and effectiveness of personnel" in the delivery of service, the manpower specialist is not only concerned with the labor market supply of workers, but is also concerned with the organizational environment within which people work and with alternative ways of structuring the work to improve effectiveness and efficiency.

In this context, manpower development is a part of organizational development. As agencies grow and mature, they need to respond or adapt to a variety of internal and environmental changes. These factors may require a restructuring of the organization, new types of staff and/or establishment of purposes and objectives. One function of the manager is to anticipate and plan for change. One approach to changing an organization is to produce change in the people in it. This change may be in terms of skills, attitudes, participation, commitment or work satisfaction. The usual organization development (OD) activity tends to focus on changing people through the use of T-groups, sensitivity training, conflict resolution sessions and communication classes. In a larger view of organizational development, the manager needs to balance the needs of the organization and the needs of individuals with the forces of change. Within this larger meaning of organizational development, a manpower development program can be a major tool.

Management Concerns

Studies of managerial behavior indicate that administrators are usually not interested in the technicalities of job classification or training or planning or human resource development. They are concerned about the general functioning and effectiveness of their agencies, and attend to specific problems that interfere with performance.

Quinn empirically identified six objectives that a large number of public administrators reported they pursued in increasing agency functioning performance.[21] These objectives were:

- Output -- increasing the quantity, quality, timeliness, and/or consumer satisfaction of the agency services;
- Coordination -- improving the planning, integration, and relationships between units;
- Motivational Climate -- improving staff initiative, satisfaction, cooperation, and creativity;
- Equilibrium -- balancing the various tensions in the organization;
- Savings -- conserving resources;
- Acquisition of resources -- increasing revenues, growth, or ability to secure resources.

Quinn also investigated the means used by administrators to achieve improvement in the various dimensions. He found, for example, that changing work methods improved goal achievement but had a negative effect on motivation. Developing policy teams, delegating authority and clarifying relationships improved coordination and the motivational climate but did not significantly affect levels of output. However, each dimension suggests strategies

the manager might use to improve agency performance. Such strategies include changing worker attitudes, reorganization, job redesign, modifying supervisory relationships, and introducing new technology. Each of these has an effect on manpower and each may be used to deal with a manpower issue.

The adequacy of mental health services depends as much upon the organization of personnel as it does on their sheer numbers. It depends as much on the motivation of the worker to do the job as on the geographic location of the service. The concepts of utilization and productivity focus attention on the manner in which staff are organized, on the potential artificial barriers to improved utilization, and on ways of gauging adequate performance.

Manpower Utilization

Ultimately, people deliver services and, in theory, "every service issue is a manpower issue."[12] The issue of having the "right" people with the "right" skills at the "right" place at the "right" time doing the "right" thing is essentially a question of how manpower is used. It is convenient to discuss questions of this nature under the rubric manpower utilization.

It is alleged[5,7] that the current production and supply of health and mental health manpower is adequate to meet future manpower needs. (This avoids a definition of "need.") This allegation is a general one and requires modification for some specialties (e.g., geriatric psychiatry) and locations (e.g., rural areas). In spite of specific shortages of special skills, one can assume that there will not be any major expansion in the overall numbers and types of mental health workers. This implies that mental health program

MANPOWER INCIDENT

Background

One department of mental health faced an acute shortage of LPNs and RNs. As the department moved toward meeting ICF/MR and SNF requirements, the need to employ these nurses became imperative. The employment problem was particularly serious at one large residential facility located in a small, rural town.

Analysis

A review of the available supply of LPNs and RNs in the area revealed that there was not a sufficient number to meet the requirements of the facility. The solution to the problem seemed to lie in developing licensed nurses from the present staff. The residential staff met with the administrators of a local hospital and worked out an arrangement where six current employees could participate in an LPN training program at the hospital. They would be allowed to attend classes one-half day as part of their work schedule.

Action and Results

All of the employees who enrolled in the program completed it and are now performing licensed nurse duties, including medication administration at the residential center. The LPN program is continuing and negotiations are underway to secure additional LPN training from the state's vocational training system. The actual classroom work will now be done at the residential facility.

MANPOWER INCIDENT

Background

Each of the community residences for the mentally retarded housed nine clients with a staffing complement of one supervisor, four mental retardation specialists, and one cook. The cooks within the system began to complain about having to work split shifts and many raised questions and lodged protests when asked to perform duties they felt were not in keeping with the job classification. They were hesitant to perform any duties except cooking. Their pay grades were lower than the mental retardation specialists although they were asked to perform many of the same duties.

Analysis

The central personnel office conducted job audits on several of the cook positions and found that, indeed, many cooks performed duties that were similar to those performed by mental retardation specialists. While some complained about duties outside of their job classifications, others were willing to assist the clients. It was also noted that it was necessary to schedule both a cook and a mental retardation specialist at times when one employee could easily cover the shift.

Action and Results

The cooks were reclassified to mental retardation specialists with cooking occupying only a part of their time. The other mental retardation specialists were advised that assisting with meal preparation was part of their assigned duties. The solution created better employee morale as well as a more efficient utilization of manpower. With the upgrading of the cook classification, more efficient scheduling has been maintained.

directors concerned with increasing the amount of services or developing new services will need to look at how existing personnel can be used and how their effectiveness and efficiency can be increased. "Bold new approaches" to service delivery may have to be mounted within the parameters of existing manpower levels. Technological breakthroughs can increase the amount of service a given worker can produce, but are unlikely to increase the number of workers.

Manpower utilization is concerned with issues related to the following:

- Amount and type of services possible with a given manpower pool;
- Organization of the tasks to be done;
- Organization of staff;
- Staffing levels and patterns;
- Type and nature of supervision required.

Some factors which influence the use of personnel lie outside the mental health agency itself. Personnel systems policies and procedures may act as a help or hinderance to a flexible use of the manpower pool. Examples of personnel practices which affect utilization are the use of part-time workers, salary differentials for less desireable jobs, use of free time, or the availability of career ladders.

Many factors are related to the practices of the mental health agency itself. Work activity may be organized by purpose, process, location or clientele. Within each type of organization there are needs for scheduling work flow, minimizing time spent in nonproductive activities, and providing adequate support services to the care-giving staff.

Another group of factors is related to the assumptions, values, and philosophies which underlie the design of the delivery system. Assumptions about the required quality of services will affect the use of manpower, e.g., group vs. individual treatment. The relative value placed on accessibility and availability of services helps determine how staff are dispersed. Although some dispositions will be less efficient than others, the importance of accessibility may require such an organization. The current philosophy of deinstitutionalization raises questions about the use of manpower to provide community services compared to hospital-based services.

Philosophies

The purposes and objectives of mental health services provide a basis for organizing staff and utilizing personnel. Funding sources frequently specify what services will be reimbursed based on their own philosophy of care. The planners and managers of service systems usually have a philosophy about the nature of emotional disturbance and the way clients should be treated. For example, some believe that public mental health care should only be provided for the mentally ill, while others feel that care should also be provided to clients who wish to develop more adequate levels of social functioning. Differences in the philosophy of care among the managers and workers in the service system can easily result in the staff utilizing their time inefficiently as seen by the managers.

As an illustration, mental health services may be organized on the basis of one or more of the philosophical positions indicated below.[22] Each will influence the derived demand for manpower, the organization of staff, and the use of the worker.

Medical/Treatment Model: This is the traditional position that assumes that a mental disorder is an illness like a physical illness. Treatment requires a diagnosis, a search for an etiological agent, and medical intervention. The consumers of services are seen as "patients." Services tend to be hospital- and clinic-oriented. The goal of the treatment is (usually) to "cure" the patient or control psychopathology.

Psychological/Behavioral Model: This model assumes that mental disorder arises from the psychological reactions of the individual to past and/or current events. Treatment helps the individual to gain insight into the reasons for his/her behavior and to change the behavior. Psychotherapy is usually the treatment of choice although behavior therapy and medication may also be used. Staff members tend to be described as psychotherapists, counselors, and caseworkers. The goal of the services is (usually) to "adjust" the individual.

Social/Learning Model: This model assumes that the basic issues lie in the interpersonal and social relationships of the client. The previous experiences of the client may or may not be judged important. The focus is on the "here and now." The client needs to learn new patterns of interaction with other people and with the world. The interventions are aimed at creating new interpersonal action patterns, reeducation, and skill development. A client is not necessarily "sick" or "maladjusted," but simply is not realizing his/her full potential. Many of the human growth and development programs grow out of this model. The goal is (usually) for the client to "adopt" new patterns of behavior.

Social/Ecological Model: This model assumes that the major cause of distress lies in the nature of society and in social institutions. The problems of racism, ageism, poverty, lack of opportunity, and perhaps pollution are seen as causal agents. The task is not to "adjust" the person to the society, but to change the social system to allow for more freedom and choices. The individual may need to learn new skills to make best use of this freedom, but the practitioners often see themselves as social activists to secure human rights and improve the quality of life. The goal is (usually) for the social system to become more "responsive" to individual needs.

Each of these descriptions is clearly an oversimplification and each has its place in the array of emotional disorders occuring in the population. Each also has direct implications for the number, type, and organization of staff. While most public mental health agencies do not have a primary mandate in the social/learning or social/ecological areas, there are subgroups in the general population who request such services. A manpower development program might undertake to analyze the size of the various populations at risk for the various "models" of service and judge the adequacy of the existing providers of service against the needs of the various sub-populations. The development of a strategy to improve the availability of services which lie outside the direct jurisdiction of the state program could reduce the demands made on the state system. An analysis of manpower needs based on the philosophy of intervention may indicate that the number of staff is less a problem than a mismatch between philosophy and type of service to be rendered.

There is also a debate as to what types of problems are to be included in a mental health program. Are rehabilitation, child care, and marital counseling included? Are alcoholism and drug abuse included? Obviously these questions are answered uniquely for almost every program, depending on local responsibilities and legal mandates. Each has implications for the utilization of manpower.

Other Utilization Issues

Another illustration of a manpower utilization issue arises from the complementary nature of much of the work in mental health services. The functioning of a surgical operating "team" is an example of what is known as

"complementarity."[23] Each member of the team performs one or more necessary tasks which contributes to the achievement of a common service goal. The "team" concept has been popular in mental health for some time and presumes to bring coordinated expertise to bear on the client's problems. However, it is not clear that mental health teams demonstrate "complementarity," as each team member seldom contributes a unique service to the client. Certainly, the operation of a mental health service unit requires the contribution of several types of staff to produce an outcome, i.e., a successful episode of client care. Little is known about what types of teams work best or whether teams are more effective than other forms of service delivery. The "team" may be an efficient way to decentralize authority and/or supervise staff, independent of its effectiveness in intervention.

Another characteristic of mental health programs is "substitutability." We may think of substituting readily available personnel for those that are less available or nonavailable. There are many activities in mental health for which several types of staff can substitute for another with no apparent difference in outcome. A study by the University Research Corporation[18] of the functions performed by community mental health centers indicated many functions are performed by almost everyone. Several types of staff "receive new clients," "communicate and interact with clients," and "perform intake interviews." The data does not distinguish between the possible levels of difficulty or intent of these interactions. It is important to determine the common and unique functions of each category of worker and design jobs

to optimize the use of each individual. Functional Job Analysis is one technique that has been used to analyze tasks in this manner.[24]

Manpower Productivity

As noted previously, a public service organization is different from a private organization in that there is no profit margin or manufactured product to act as the bottom line against which to judge the effectiveness and efficiency of the operation. Other characteristics of "for profit" organizations, such as rates of return on investment, market penetration, and competition for buyers, are also missing. In general there is a lack of knowledge about the "production function" in mental health. That is, there is little agreement on the specific inputs or the sequence of inputs required to produce a given output or array of outputs. Public programs are typically asked to achieve several objectives simultaneously with essentially the same manpower pool, thereby making the output/input relationship complex. As noted earlier, this may lead to uncertainty of individual staff members regarding their specific contribution to the organization. The multiple objectives of the agency make the assessment of agency and worker productivity less certain. In publicly-funded programs there is generally a limit to the number of persons who can or will be employed, because there is a limit to the monies that will be allocated to agencies to deliver services. The ability of the limited work force to produce the required services becomes a matter of manpower management.

Manpower requirements are a function of the services to be provided and the productivity of staff. Program directors need to be concerned about the productivity of their work force when they are concerned about manpower needs. Productivity has received little attention in mental health agencies. In fact, the concept of productivity is alien to the mental health field because of traditional values of providing the highest quality of service to clients regardless of cost. Productivity has received attention in the physical health field,[25] where the major focus has been on increasing the amount of primary health care delivered by physicians. The productivity of physicians has been increased by the use of new technologies or by the use of various kinds of physician extenders. It is less clear whether the same degree of increase can be obtained in mental health by similar means. There is also the question of what is meant by productivity in mental health agencies.

Meaning of Productivity

Productivity is typically defined as the ratio of output to input. It is a ratio between what is produced and what is required to attain that production. The ratio is essentially an arbitrary relationship between any two quantities of interest. Such a ratio is an index, not a mathematical equation. The U.S. Bureau of Labor Statistics routinely publishes a variety of measures related to production per worker hour and unit labor costs. These indicators are used to describe and analyze the national economy as well as specific industries.

Illustrations of possible productivity indicators in mental health are:

- Number of episodes per service unit;
- Number of units of service delivered per month;
- Number of episodes of care per total agency expenditures;
- Number of clients served per staff member;
- Number of direct service hours per staff hours available;
- Amount of revenue produced per cost of service.

Productivity may be increased by either (a) an increase in output for the same amount of input, or (b) a decrease in input for the same amount of output. Productivity indices can be used to compare existing productivity with an established standard, to compare two time periods, or to compare alternative mixes of inputs. Productivity indices need to be developed which take into account quality of output as well as quantity of output.

The illustrations given above are selected to call attention to several aspects of productivity. First, indices may be developed which reflect productivity of the organization or productivity of individuals. Organizational productivity is not merely the aggregate of the productivity of individual staff members. One assumes there are different strategies to improve the productivity of the organization or of the individual. Second, indices may be developed with or without using "dollars" as part of the index. Second, indices may be developed with or without using "dollars" as part of the index. Third, many types of productivity measures can be developed depending on the aspect of agency or worker activity in which one is interested. Fourth, there is always a problem of selecting appropriate output measures. It is remarkably easy to become involved in debates as to what is the "real" output of a mental health program, e.g., the amount of service available and/or the

amount of service delivered, and/or the level of client functioning achieved, and/or the mental health status of the community.

One guideline for the selection of output measures is the answer to the question, "For what results can I/we legitimately be held accountable." Since the answer will vary from setting to setting, there is not a single productivity index. Currently, many mental health centers depend increasingly on outside revenue for survival. In these instances the number of reimbursable hours generated per total hours available becomes a significant productivity indicator in monitoring agency operation.

Uses of Productivity Indices:

As suggested above, one use of productivity indices is to monitor critical aspects of agency operations. Productivity indices can also be used to set performance expectations for staff or organizational units. Such expectations can clarify the fuzzy statement of objectives which are sometimes present in mental health delivery systems. Baseline productivity measures can be used to budget for future services and, consequently, for manpower needs. Comparison of routine productivity measures can also indicate decreases in productivity and alert the manager to take corrective action.

Some of the factors which influence productivity are worker competence, task assignment, technology, and worker motivation or disposition. A worker has to have the basic knowledge and skill required to adequately perform the tasks assigned. Training aimed at increasing competence has been shown to increase productivity when the basic skills are not present.[26] Once the

basic skills are present, greater knowledge or skill levels do not necessarily lead to better performance. Greater productivity is then frequently related to the organizational climate. Therefore, manpower development is concerned not only with productivity per se but with human development and organizational development activities that encourage greater performance.

Manpower Management

The purpose of this discussion of utilization and productivity is to suggest the array of service and management issues which are related to manpower development. These issues are most relevant to the internal management of the program and, in large measure, are susceptible to modification by program managers. As mental health managers have greater control of the factors related to utilization and productivity, attention to these issues may provide some immediate payoff for manpower development activities.

Most mental health program directors are immersed in webs of constantly changing environmental factors which have impact on their agencies. The political climate of state legislatures, the economic conditions of the state, the turf battles between and within state agencies, and the shifting initiatives and regulations of federal programs occupy a large portion of a state director's attention. If public administrators are interested in improving output, coordination, motivational climate, and savings, they can use manpower development activities to assist in these issues. The director has an active role to play in both the internal management of the

organization and its use of manpower (utilization and productivity), and at the interface between the mental health program and actors external to the agency (supply and distribution).

Chapter IV

FUNCTIONS OF A STATE MANPOWER PROGRAM

The organizational structure and management of a state manpower development program will be discussed in a future publication. This chapter will deal with the functional activities that could, or should, be carried out under the aegis of such a program. Our previous definition of a manpower development program was that it was "an organized and systematic series of activities...." However, there are almost an indefinite number of specific activities that might be included under the rubric of manpower development, and there are a large number of ways in which specific tasks may be grouped or organized into sets of activities. At this point it is more appropriate to consider what functions a manpower development program might perform (and the outputs expected) than to focus on specific tasks a manpower program might carry out.

Research in the area of work and worker behavior has produced a complex terminology to describe the relationship between workers, what workers do, and what gets done.[24] The "what gets done" (a task) is the result of what the worker does (a behavior). In this discussion we will use the following terms:

> A task is a specific, discrete piece of work, e.g., tabulates data, or contracts all referred clients;
>
> An activities is made up of several tasks which together achieve a result, e.g., maintains a data base or records client's mental status;
>
> A function is a combination of activities performed for a given objective, e.g., acquiring and analyzing data or establishing level of client functioning;

A role is made up of one or more functions which are combined to achieve a given goal, e.g., to evaluate a manpower program or to provide case management services.

In general, roles and functions focus on what work is accomplished, while activities and tasks focus on what the worker does. These distinctions are less important to maintain in an absolute sense than to provide guidelines for discussion of a manpower development program. The roles a state program could play in manpower development, which were suggested in Chapter II, will be used as the framework for discussing the major functions of a manpower program. The functions and activities of each role are interdependent. Any specific state or agency establishing a manpower program will need to think through the roles, functions, activities, and tasks in the context of their own purposes, goals, and resources.

Identifying Manpower Objectives

Given the nature of the manpower "system" and the broad concept of manpower development presented here, an appropriate question is "Where is the best place to start in developing a manpower program?"

The most appropriate answer is to begin with existing service and staff problems. As Kimmel notes,[12] the single most important way to organize thinking about manpower development is to focus on issues of concern to the managers of the agency. The conduct of manpower development activities will then be relevant to them. Management issues are likely to fall into one of three broad categories -- service delivery, allocation of

MANPOWER INCIDENT

Background

Several years ago a large psychiatric hospital in one area of the state had a significant problem with psychiatric aide turnover. The problem was blamed on poor salaries, the type of work, lack of motivation, etc.

Analysis

A thorough study of the problem confirmed that salaries, the work, and type of employees were factors in the amount of turnover at the hospital. The study also revealed that it was difficult for many employees who lived in the inner city to find transportation to the rural location of the hospital. There was no public transportation to the area and many employees did not own cars.

Action and Results

After analyzing where the current aides resided and where those who had resigned had lived, a plan was devised whereby the hospital would run its own transportation system for these employees. Arrangements were made to acquire buses from another state project. Unfortunately, the commissioner was not interested. All he could see was that he would have to hire a bus driver and this made it too much of a problem for him. The high turnover rate continued.

MANPOWER INCIDENT

Background

The remote, rural location of a state hospital presented difficulties in recruiting and retaining medical staff. In 1964, the staff consisted of a number of foreign-trained physicians, most of whom were Cubans who had fled their country. At first the physicians expected their exile to be a short one and that they would soon return to Cuba. It was soon apparent that this would not happen and that they would have to learn the language and culture of the people they were serving. Their contact with the cultural environment was limited as they lived in state housing on the hospital grounds several miles from town.

Analysis

The state mental health manpower commission conducted a survey of these physicians and their families and found that they were sincerely interested in learning our language and culture.

Action and Results

The commission contacted the faculty of a local college and volunteers were recruited from the language department to tutor the medical staff and their families. They were encouraged to move into town so that they could more quickly assimilate the language and culture. Through this program the physicians were better able to treat the patients in the hospital and their families were better integrated into the community. Several of the physicians later passed the examination of the Educational Council for Foreign Medical Graduates and became fully licensed to practice medicine in the community. When the state hospital was closed in 1977 many of them remained in the community.

resources, and policy development. Manpower development activities which are focused on service delivery problems will also have impact on the allocation of resources and policy issues.

It is not difficult to locate problems although it may be difficult to place priorities on them and decide how to deal with them. The following is a selection of manpower issues indicated (1978) by state mental health program directors and staff to identify significant manpower problems in their jurisdictions.

- Knowing existing manpower resources
- Meeting staffing standards
- Retaining staff
- Assessing output of job performance
- Shifting patient population
- Retraining hospital staff
- Applying training to work settings
- Rewriting inadequate job descriptions

Each of these offers a place to initiate manpower activities. Problems that are broader in scope can be identified by examining the existing service commitments of the agency, the types of service demanded by the client population, the responsibilities mandated by state or federal legislation, and the questions asked in state budget hearings.

Still broader manpower issues can be found by identifying the agencies outside of mental health whose operations affect mental health manpower. Such activity not only identifies potential manpower problem areas, it also identifies elements of the manpower system with which the agency may have to work. It requires a "system" orientation to look beyond the boundaries of the mental health agency and incorporate the other relevant actors into

service delivery and manpower planning. An understanding of these extramural actors allows for a better understanding of how the state mental health agency can interact with them to achieve manpower goals.

Information Collection and Analysis

A major need of any program or agency is relevant information upon which to base its actions. This is not to say that data determines decisions, but some level of information is required to manage manpower resources. This is essentially the role of the "sensor." The functions included in this role may be described as acquiring, analyzing, and presenting information. The information is used to describe, compare, monitor, and forecast manpower and service patterns.

Formal data collection procedures may not be necessary to identify problems, analyze issues, or predict future conditions, as routine management processes often provide such data. However, more formal data may be needed to document the extent of the problems. For example, everyone "knew" that many foreign medical graduates (FMGs) were employed by state mental health programs. Federal legislation (PL 94-484), limiting the supply of foreign medical graduates, stimulated more formal data collection which showed that FMGs constituted over 50 percent of the psychiatric staff of state and county hospitals.[14] This finding more clearly described the scope of the problem on the national level. Additional data collection and analysis is required at a state level, as some states are more dependent on FMGs than others.

MANPOWER INCIDENT

Background

Our agency initiated legislation in 1974 to require all physicians in state hospitals to be licensed. The law was to take effect January, 1977. Plans to implement the law were not discussed until right before the law went into effect. In November, 1976 one of the state hospital directors resigned on the basis that so little planning had been done that the hospitals would have to be operated without physicians.

Analysis

This resignation set off a flurry of activity as to what had actually been done to prepare for the effects of the legislation. We discovered that the staff development people had spent over $180,000 conducting training workshops to prepare hospital physicians for licensure. However, as soon as the physicians were licensed they left the state for positions with an average salary increase of 80 percent.

Action and Results

We convinced the personnel administration that we had performed reasonable and legitimate activities in an attempt to upgrade our physicians. After a series of meetings with personnel and a salary survey of other states, the salaries in our hospitals were raised to a competitive level. Within two months the hospital whose director had resigned had more physicians than it had had previously.

MANPOWER INCIDENT

Background

During the last session the legislature abolished 58 civil service positions from the 4,681 previously-funded positions in the state mental health program. The choice of which positions to abolish was essentially arbitrary as they usually were professional positions which had been vacant for twelve months because of recruitment problems.

Analysis

This situation was seen as a manpower planning issue. It was apparent that the mental health office lacked basic manpower information about programs under its jurisdiction. Information on manpower allocations that would allow comparison and analysis of utilization patterns was not available.

Action and Results

A portion of the state 314(d) funds was used to develop a contract with a group of professional management consultants to study the allocations of staff in the CMHC's and state hospitals. The study results have been useful in preparing recommendations for utilization of vacant positions, thus defending deletion of more positions. The study results will also serve as the basis for a proposal to NIMH regarding state manpower development.

The perceived need, or desire, for data about manpower seems almost universal. However, it is not clear what data should be collected or how the data should be used. In mental health there is no agreed-upon relationship between client needs and provision of specific services, and no agreed-upon model relating specific services to manpower requirements. As others have indicated,[12,16] it is easy to become immersed in the technology of developing a data base before one knows what to do with the numbers. Therefore, a crucial set of activities required in the sensor role is the identification of the key questions in the key areas about which information is needed. Already identified service problems clearly suggest a place to start.

State mental health staff often express a need to know what kind of personnel are currently employed. The traditional way of assessing manpower is to count the number of individuals who fall into various categories. The categories may be derived from worker characteristics, such as age, sex, occupation, years of experience. Other categories may be derived from the characteristics of the services provided, such as treatment, rehabilitation, crisis stabilization. Still other categories may be determined by the settings in which services are offered, such as ambulatory, hospital, community, rural. There is need to decide which types of data are most useful for the problem at hand.

Another type of information concerns manpower requirements. Traditionally, personnel divisions attempt to match the characteristics of potential employees with the characteristics of positions through a standard set of job descriptions. Job descriptions attempt to specify the requirements of positions

in terms of discipline (e.g., Psychologist IV), or function (e.g., Counselor), or setting (e.g., Alcohol Unit Supervisor). Thus, both the type of job descriptions authorized and the organization of services generate certain "demands" for manpower. The matching of worker characteristics with service characteristics has proven difficult when job descriptions are based on discipline/education requirements. A particular educational background does not guarantee the ability to competently perform the specific tasks of a position. If tasks and activities are changed to conform to new modes of service, personnel system data describing jobs may or may not provide information on whether the necessary skills are available in the current work force. Some states and agencies are attempting to build a profile of current staff skills to more accurately estimate manpower resources. This type of data may be developed by relating staff assignments to services rendered, by relating actual functions to job descriptions, and/or analyzing the relationship of competencies to job titles.

Another framework for gathering data is to organize manpower issues according to the factors of supply, distribution, utilization and productivity. Concern with manpower supply focuses on the external labor market, potential workers in the pipeline, the interface between the agency and the outside environment, and the roles of other agencies in providing mental health services. Concern with distribution of manpower focuses on the rewards and attractiveness of the job available, the location of demands for service, working conditions, and credentialing regulations. Concern with utilization

focuses on staffing patterns, scheduling procedures, relevance of services, and delegation of tasks. Concern with productivity of manpower focuses on skill development, staff burnout, organizational climate, and staff activity reports.

These comments suggest the range of activities which can be involved in the role of sensor. While there is a need to have an adequate manpower data base, new data collection should be delayed until existing data sources are thoroughly investigated. Much data already exists in payroll files, personnel files, regulating and credentialing boards, health planning agencies, and educational institutions. The relevance and usefulness of this information should be considered before starting a new data base. Obviously, if a manpower development office is to focus on problems and their resolutions, information is needed that identifies the problem and evaluates whether the actions taken have caused a change in the situation. The major unresolved issue is the type of data needed that will provide adequate and useful indicators of manpower status.

Planning

After a service or manpower problem has been identified and documented, the next logical step is to plan to do something. In this instance, planning is viewed as encompassing those functions and activities required to establish a course(s) of action to be taken to deal with a problem. The role of "planner" includes the functions relevant to developing a plan and in recommending policy actions to appropriate decision makers.

MANPOWER INCIDENT

Background

There was only one Master of Social Work (MSW) graduate in the four state hospitals and central office of the Department of Mental Health when it was established in 1952. To increase the number of MSWs in service, the state mental health association provided training stipends to students who would agree to work in the state system after graduation. In 1954, the state legislature appropriated funds to continue the stipend program. The number of social workers increased greatly as a result of graduates completing their obligation to the state and from newly-recruited MSWs. In 1965, the need for the stipend program was questioned, since a large number of the stipend recipients left the state after completing their period of obligated service.

Analysis

The state's manpower commission studied the social work training program and the state's need for MSWs. While more were needed, it appeared that they could be recruited from social work graduates without the need for training stipends. The study also indicated that the movement of young social workers after their initial two years of employment was a typical career pattern and not the result of job dissatisfaction.

Action and Results

The manpower commission recommended that the stipend program be discontinued except for bachelor-level social workers who were already employed with the state and who wanted to further their careers. The state was indeed able to recruit the MSW personnel it needed in the open market in sufficient numbers to fill all staffing needs. The stipends were phased out over a period of years with a resulting savings in state monies.

MANPOWER INCIDENT

Background

In a residential facility, medication for residents was prescribed by a physician, dispensed by a pharmacist, and administered by cottage personnel. To qualify for XIX funds, the facilities had to meet ICF standards. These regulations specify that only RNs and LPNs can administer medication.

Analysis

Both RNs and LPNs were in short supply due to the limited number of positions available and the low salaries. The facilities faced the loss of a major source of support because of the inability to meet ICF standards.

Action and Results

With the approval of the Title XIX program, a limited number of cottage aides were given special training (Physician's Assistance Medication Course) which allowed them to administer medication under appropriate supervision. Temporarily, the facilities continue to receive funds but full compliance will soon be required. No planning has been done to develop the needed personnel. A manpower development plan could include new staffing patterns, a recruitment campaign, and long-range training plans.

A state manpower development program is likely to be involved with several types of plans. The Community Mental Health Centers Amendments law (PL 94-63) requires that state mental health agencies develop a mental health services plan which includes a manpower component. Currently, this component usually includes a summary of existing personnel by type and by location with an indication of the additional personnel needed to meet staffing standards. It may also include projections of future personnel requirements associated with planned services by discipline or by service setting, or both, e.g., "eight clinical social workers to serve as district supervisors." The services plan also may include a description of staff development activities. The data and narrative of the manpower component are frequently used to describe budget constraints and support budget requests. This plan is primarily concerned with the public mental health services.

A second type of plan is one that is concerned with an overall statewide manpower development plan. While such a statewide manpower development plan might be derived from the needs of the public service system alone, it can also be concerned with the manpower needed in the private sector, universities, correctional institutions, etc. The components of an overall manpower development plan should address the organization and structure of all major actors in the manpower system, the function of each, the basis for decisions, and the method by which actions are initiated. The focus of this type of plan is broader and more long-range than the manpower component of the required mental health services plan.

The third type is an action plan concerned with the resolution of an identified problem in the delivery system. This plan is specific and usually requires a shorter time frame for action. It is suggested that a manpower development program start with such an identified problem and action plan. Added to that is the suggestion that it be started with a problem about which something can reasonably be expected to be done within the limitations of the agency's responsibility and jurisdiction. The type of problem identified (agency-wide, overall, specific) will clearly influence both the resources and capabilities required to deal with it.

The distinction among types of plans is of some importance, as the scope of the planning to be done will, in large measure, determine the staffing and organization of the planning process itself. The organizing process is one of the activities involved in plan development. Plan development also includes a definition of the manpower objectives to be achieved, who will be involved in the planning, and who will direct the effort. The next plan development activity is to identify strategies and programs which are judged likely to achieve the objectives. For any problem there is apt to be more than one strategy (e.g., continuing education or basic education) and/or program (e.g., student stipends or field placement) which may reasonably be expected to deal with the issue. The planning process requires establishing criteria against which the suggested programs can be judged. A number of planning and priority-setting techniques which can be used are available (see reference 27).

The final step in plan development is to actually draft a plan for consideration by the appropriate decision-maker. A convenient format for the presentation of alternative strategies and programs is that espoused by the currently popular zero-based approach to budgeting.[28] The format includes a presentation of alternative methods of achieving the objectives combined with different levels of resources that would be required to achieve differing levels of output. The advantage here is that a decision can be made in the context of several choices and priorities. There are, of course, other methods or styles of preparing a plan, but in any case, the result should be a recommended plan for action.

A second major function of the planner role is to develop policy recommendations. Policy development is the process of deciding among the alternative directions to be taken regarding some aspect of manpower. Here the choice among alternatives is not only at the level of specific program activities but also at the more general level of agency philosophy and commitment. Will the agency support continuing education programs for staff? If so, under what conditions? Will the state mental health agency seek working agreements with other state agencies or with institutions of higher education relative to manpower? Will the agency be concerned about retraining or relocating hospital staff if deinstitutionalization is instituted? Will pension benefits be kept intact?

Policy development at this level involves political and social values as well as the philosophy of treatment. It is not usually the responsibility

of the manpower development program to establish these values and philosophies, but it can identify the policy options and make recommendations which help clarify these values and philosophies.

Implementation

The role of "facilitator" is perhaps the most difficult to describe. In the simplest form it consists of helping to implement the manpower development plans and/or policy recommendations. It is not sufficient to identify problems, analyze data, and plan without also assisting in implementing the program. Usually the authority or responsibility for implementation will not lie in the jurisdiction of the manpower development program. "Manpower development" is essentially a means, not an end. One should keep asking the question, "Manpower development for what?"

In this document we answer that question in two ways:

1. The purpose is to ensure that manpower resources and capabilities are adequate to meet the requirements for delivery of mental health services to the population.
2. The goal is to help resolve manpower and service problems.

While the manpower development specialist may not be able to assure action, he/she can help establish the psychological mind-set that something can be done and help program managers take appropriate actions. This function might be viewed as advocacy for the actions and concepts of manpower development with those persons in the service system who are responsible for, or affected by, manpower activities. The manpower development specialist needs to be able to communicate the plans or policies decided on in such a way that appropriate

audiences understand what action is planned and have an opportunity to provide input. The techniques of communication run the gamut of public distribution of plans, statewide conferences, or reports to advisory boards. One device suggested by Kimmel[9] is the preparation of an "issue paper" which serves to focus ideas and actions around issues which are not yet clearly specified. This document may be seen as an "issue paper" designed to initiate thoughtful consideration about developing manpower capabilities. The issue paper then becomes a focus of discussion around which additional activities are initiated.

Other functions in this role are those associated with the review of ongoing programs to see if they are achieving the results expected. This is related to the data collection and analysis functions of the sensor role. The organization and operations of the manpower program itself require review to allocate resources effectively and to develop additional capabilities.

Linking Manpower Development Capabilities

The specific organizational structure of a manpower development effort may be less important than its ability to link, or integrate, the existing manpower capabilities within the agency or state. Most state mental health agencies already maintain activities in personnel administration, data collection, training, planning, and budgeting. These various activities may differ in their level of sophistication and in their degree of interaction with each other. Whatever the situation, the manpower development program needs to link these many capabilities to successfully perform the functions of the other roles noted above.

MANPOWER INCIDENT

Background

A residential facility for approximately 1,000 mentally retarded persons needed two physicians to provide diagnostic and evaluation services for admissions and medical services to residents. The positions called for skills in a number of areas with around-the-clock medical coverage. It was almost impossible to attract applicants for the positions. Medical services were delayed; accreditation standards were not met.

Analysis

The state salary scale was low for physicians and the the work was demanding. One of the positions remained vacant most of the time, placing additional demands on the remaining staff. It appeared highly unlikely that the salary scale or work requirements could be changed to make the position more attractive.

Action and Results

A contract was negotiated between the facility and the state medical center whereby medical students provided the needed services. The medical students met their needed internship experiences and also received training which made them potential service providers to the mentally retarded in the future.

MANPOWER INCIDENT

Background

A third-year graduate student in clinical psychology, supported by an NIMH grant to that department, was placed in a local CMHC to meet his practicum requirements in psychological assessment. The department was also very interested in behavior modification research and had given this promising student a research assistantship. The CMHC placement also provided access to subjects for research.

The CMHC assumed that the psychology program had prepared the student in the basics of clinical work and assigned him to do a diagnostic "work-up" of an adolescent boy. Actually, the student had had only theory courses and was not familiar with practical evaluation procedures. He was unable to do the task and replied that he was a "psychologist," the work-up was "mickey mouse," and he did only "behavior modification."

Analysis

There was a mismatch of expectations between the university and the service agency. The CMHC assumed that the university would provide the basic clinical training while it would provide field experience in return for the possibility of later recruiting properly trained clinicians. The faculty's expectations were that they would concentrate on research and the service agency would make up for any technical weaknesses or omissions in clinical training.

Action and Results

Complaints that professional training programs have overlooked public service needs have been heard by Congress and threaten to reduce or eliminate funds for these programs. Such action would harm the universities whose students need practical experience and the service agencies who need a "pool" of trained graduates from which to recruit.

This role has been called "coordinator." It is not meant to convey an impression that the manpower program controls all these capabilities or that they are transferred to its bureaucratic jurisdiction. Here we are concerned with the functions of coordination.

A recent study of "linkage systems mechanisms" in health manpower planning[29] identified the following factors that were related to successful linking programs:

- The clear assignment of responsibility for linkage at an appropriate level in the hierarchy;
- The establishment of a pattern of operations congruent with the structure of the state;
- The utilization of competent staff that is more generalist-oriented than specialist-oriented;
- The establishment of linkages with the whole range of concerned representatives;
- The utilization of a manpower data base.

The findings have clear implications for a manpower development program. In establishing the program, there should be clear sanctions and authority delegated by top management to whomever is to be responsible. The responsible person should be in reasonable proximity to the decision-maker. That is, a manpower program representative three or four levels removed from the decision-maker is not apt to be seen as having the authority to link and coordinate activities. The manpower development program needs close contact with the decision-makers to have a full understanding of service/manpower issues. The "best" organizational location for the program will depend on the existing

structure and operating style of the state or agency. Depending on the existing capabilities, an initial group of persons from the various divisions within the agency can begin to explore and develop an initial plan for manpower activities. The activities of this group should be legitimized by an executive decision-maker so that it is not seen as the "manpower specialist" calling a meeting.

Finally, the manpower development program staff -- whether one person or several people -- must be sensitive to the potential anxieties a new activity can generate. The job is to identify and integrate resources, not to create another bureau. Most of all, agency staff need to see the advantages of the process -- "linking" -- to manpower development.

Chapter V

A MANPOWER DEVELOPMENT PROGRAM

The point has been made that linkage mechanisms work best when they are designed to be compatible with the existing organizational structure and style of the agency. Most managers, at one time or another, are faced with the need to make the organization more productive, to reevaluate existing methods of operations, to reorganize operational units, and to plan for change. Certainly, "change" is a primary issue facing a manager in today's mental health system. Mental health agencies will need to examine their current manpower development activities -- whether those activities are formally or informally sanctioned -- in order to achieve more effective mental health services.

Why Establish a Manpower Program?

The previous sections have indicated what manpower development is and how it might function. That discussion suggested several reasons why such a program should be set up in terms of concepts, purposes, and objectives. A more pragmatic reason is to coordinate those activities which the state mental health program is required by law to perform. These include development of a mental health service plan (PL 94-63), coordination with mental health planning (PL 93-641), and improving the distribution of health professionals (PL 94-142). In addition, there are a variety of court decisions which have impact on manpower requirements. The most direct impacts stem from court decisions regarding staffing of state hospitals (e.g., Wyatt vs. Stickney, 1971).

There are, of course, unique state laws and regulations which affect manpower by mandating specific services, by assigning certain responsibilities to the public mental health system, and by establishing minimum standards for licensing of service providers. Staffing requirements are also promulgated by accreditation agencies and the reimbursement programs.

Most mental health agencies are already spending resources to meet standards, provide training, develop job descriptions, collect data, and other similar activities. It is then a question of determining the merits of establishing some sort of visible manpower development program to coordinate/integrate these activities in the state, or letting things go on as they are.

Establishing a Manpower Development Program

The first issue in establishing a program is to generate the motivation to do so. Exactly how motivation is developed will depend on the circumstances of the agency and initiative of the leadership. Because primary focus here is on state mental health programs, the most appropriate leader is the State Mental Health Program Director. However, there are other key leaders in human service agencies, higher education commissions, and departments of administration who can, and should, be involved in the manpower development process.

The second issue is usually how to fund a manpower program. This, too, is dependent on the circumstances of the agency. Manpower development advocates are cognizant of the resource limitations prevailing in public mental health programs. However, the general feeling of many state staff is that

if manpower development is worth doing, it is worth doing with "hard" monies. That is, the core of manpower development programs should be incorporated into the ongoing operations of the agency and funded by the agency. The core activities may be large or small, but the effort should not be completely dependent on external grant funds. Such "soft" monies can be used to broaden activities during a start-up, to develop pilot tests, to demonstrate concepts that are not otherwise possible, or to do the planning for establishing manpower development programs. The National Institute of Mental Health, through its Center for State Mental Health Manpower Development, currently has grants available for such start-up costs.

The third issue is the kind of staff and resources to assign to a manpower program. One of the problems encountered in several states was that "manpower development" was often added to the responsibilities of an existing staff member, office, or position. In all instances, manpower has had to compete with established and continuing demands for attention. There usually is a lack of time to adequately conceptualize and analyze the territory when it is added to other duties. Therefore, it is suggested that the manpower development initiative have at least one person for whom this is a primary, if not sole, responsibility.

The suggested minimum activities to be carried out are to identify inter- and intra-agency manpower resources, to develop a mechanism for coordinating existing manpower activities and to identify the state's major manpower issues. As the National Commission for Manpower Policy noted,[2]

the objective is to move manpower from the status of a "residual issue" that is dealt with in piecemeal fashion to one of "primary consideration" for at least one member of the agency staff. The professional or technical discipline of the individual is not as important as the ability to organize, facilitate and manage appropriate resources. Obviously, it would be advantageous if the staff member was also "turned on" by the ideal of developing a manpower program.

A final issue is the relation of a manpower program to other parts of the organization. As suggested, the minimal staff may consist of one person, and it may not be appropriate to establish a "Division," "Branch," or "Office" of Manpower Development. The title of the program derives from functions involved, the level of responsibility assigned, and the organizational structure. The program staff does need access to both the management decision-makers and to the service system. The manpower program staff need to be able to develop liaisons with individuals and agencies, external to the manpower program itself, to utilize that expertise and to be informed of issues as they arise. This indicates that the program needs <u>recognition and sanction</u> by top leadership, with adequate authority to carry out the necessary coordination, resource development, problem identification, and planning activities. Any organizational component needs legitimization to carry out its duties. In this case the legitimization may be more difficult to articulate because the activities cut across agency boundaries and manpower concepts are relatively new.

Future Activities

As noted in the Preface, the intent of this publication was to present the concepts of manpower development with a focus on state mental health programs. We hope that the presentation has organized those concepts in an understandable and useful way. However, this is only the first step in a continuing process of examining the many issues raised. Additional "issue papers" are planned on such topics as:

- Organization of manpower programs;
- Improving productivity in mental health;
- Human resource development;
- Staffing patterns.

These publications are not intended to be the "last word" in these topics but rather a series of guideposts. Additional ideas on issues in mental health manpower development by our readers will be appreciated.

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DEFINITIONS OF MANPOWER TERMS

Manpower - the capacity available or required in terms of personnel to deliver mental health services.

Mental Health Services - the organized programs and individual practitioners who are designated to provide diagnosis, treatment, care, and rehabilitation to the mentally ill, the emotionally disturbed, alcoholics and drug abusers, or programs of prevention for these and related conditions.

Human services - the organized programs and individual practitioners who provide diagnosis, correction, support and prevention for the range of human (bio-psycho-social) problems. This includes the mental health field as well as the fields of physical health, social services, rehabilitation, corrections, child welfare, aging, and mental retardation.

Federal - pertaining to or operated by the United States Government. Many of the federal programs that affect mental health manpower are located within NIMH or within the Alcohol, Drug Abuse, and Mental Health Administration, but there are several other units of the U.S. Government that also impinge on mental health manpower (e.g., Congress, the federal courts, the Social Security Administration, the Department of Labor, the Department of Defense, the Veterans' Administration, as well as several other components of the Department of Health, Education, and Welfare).

National - pertaining to, or maintained by, the nation as a whole. Many national professional organizations, accrediting bodies, citizen advocacy groups, and associations of state and community mental health officials, together with the official programs of the states and the federal government, make up the national mental health effort.

State - pertaining to, or maintained by, the government of a state. This refers to the official agencies and activities of the entire state government -- not just the official mental health agency -- and includes higher education agencies, licensure boards, legislatures, and merit systems.

State-level - pertaining to activities organized for all component groups or individuals within a state. This refers to activities of voluntary, private, and professional agencies and groups within a state as well as the official state agencies.

Manpower Development - the sum total of activities designed or employed to increase the numbers and effectiveness of personnel engaged in delivering mental health services to clients or communities. This defintion includes elements of planning, training, distribution, utilization, licensure, funding, evaluation, etc. It implies a range of activities that are directed to creating mental health workers and making the most effective and efficient use of those who are presently available.

Manpower data (or information) system - a mechanism for collecting and analyzing information about mental health personnel needed, available, or being trained, including their characteristics, professional activities, salaries, and movement.

Manpower policy development - the process and activities of deciding from among alternatives which courses of action will be followed in regard to various aspects of mental health manpower.

Needs assessment and projections - activities to gather and analyze information about the needs for various kinds of mental health manpower, the patterns of distribution and functioning of existing manpower so that the numbers and kinds of workers required in the future and the kinds of functions they will carry out can be estimated.

Program planning - activities to identify all issues and set a comprehensive plan of steps to be taken to train and use mental health manpower most effectively.

Program evaluation - activities to determine the relative effectiveness, costs, side effects, etc., of various parts of a manpower development program.

Administration - those activities and functions necessary to acquire and use mental health workers in the service delivery system.

Recruitment - activities to encourage persons to choose mental health careers or to induce them to select specific positions in the mental health delivery system.

Distribution - activities to encourage the needed allocation of mental health workers into all geographic and specialty areas.

Utilization - activities designed to harness the activities of mental health manpower to produce mental health services.

Career systems - patterns in agencies and in academia whereby a mental health worker can move upward or laterally to establish a continuous course of professional development and achievement.

Training - activities to prepare mental health workers for the delivery of mental health services. This includes pre-service education, continuing education and education for paraprofessionals as well as for professionals.

Educational planning - activities to assess needs and develop educational objectives, instructional methods and evaluation procedures to prepare workers to deliver mental health services.

Continuing education - planned activities to upgrade or up-date the competence of previously-trained mental health workers to deliver mental health services more effectively.

Paraprofessional education - training activities that are planned to prepare new kinds of workers or established workers for new kinds of functions in the delivery of mental health services.

Regulations - laws, rules, or officially-adopted policies and procedures related to any aspect of mental health manpower.

Sanctions - customs, practices, and social policies which influence the ways in which mental health workers are trained and used.

Mental health manpower development program - an organized and systematic series of activities designed to increase the numbers and effectiveness of mental health workers for the delivery of mental health services to clients and communities. Such a mental health manpower development program might be organized to serve a single community, or to serve a single state agency, or to serve the state-wide mental health services of all kinds -- public, private, state, and local.

State capacity-building - creating and improving the ability of a state to carry out a specific program or activity. In this case it refers to improving the ability of the state to undertake and carry out a state-level mental health manpower development program.

ELEMENTS OF MANPOWER DEVELOPMENT*

Mental Health Planning and Evaluation

These are the major "intelligence" functions of the mental health manpower system that have to do with the overview, planning, control, and accountability of the system.

Manpower Data Systems

There are many sources of mental health manpower data -- licensure boards, professional societies, facility reports to NIMH, accrediting bodies, state personnel systems, professional schools and others. It is neither feasible nor desirable to attempt to create a single computerized data system for all information developed from these sources, but it should be possible to establish better linkages of these data systems and improve the quality and usefulness of much of these individual data systems for manpower planning purposes

Manpower Policy Development

Manpower policy development includes articulating the ideologies and philosophies that underlie the use and training of manpower. Planners should state their theoretical formulations of mental disability (e.g., psychoanalytic, behavioral, social), their choices of therapeutic models (e.g., medical, behavioral, educational), their policies regarding the roles and functions of various kinds of workers (e.g., the various disciplines, paraprofessionals, volunteers), their training policies, etc. Policy is partially articulated in laws or regulations but most often it remains unstated.

Manpower Needs Assessment and Projections

The state of the art regarding assessing manpower needs and making projections is rudimentary at all levels. There are many manpower

* Abstracted from Role of the National Institute of Mental Health in Relation to State Mental Health Services Manpower, the NIMH Services Manpower Task Force, 1976.

analytic studies of gross numbers of various kinds of workers. These analyses tend to be restricted to single professions and to make straight-line projections of manpower without regard for changing economics, technology, and utilization patterns. At all levels there is need for much greater sophistication in doing mental health manpower needs assessments and making manpower projections.

Manpower Program Planning

Mental health program planning seldom includes any significant manpower planning. Usually there are crude estimates of the numbers of various kinds of workers required and a corresponding budget. When major new programs are undertaken, there may be plans for recruitment, orientation, inservice training, patterns of utilization, etc., but these plans are seldom complete when the programs are small. Such manpower planning could be a more substantial part of overall program planning if more deliberate attention were given to it.

At the federal level, NIMH has failed to include specific manpower planning in its overall service plans, and manpower criteria have not been included in NIMH program regulations or guidelines.

Colleges and universities often undertake training programs without assessing needs for the graduates or determining what knowledge and skills are wanted by the agencies.

Manpower Program Evaluation

Mental health program evaluation is still in its infancy and the same is true of evaluation for mental health manpower programs. Although there have been occasional ad hoc studies of mental health manpower programs (e.g., What was the impact of doubling the numbers of psychiatric aides?), there is very little ongoing evaluation of mental health manpower programs.

Mental Health Manpower Administration

Mental health manpower administration includes those action elements necessary to acquire and use mental health workers in the service delivery system. Some type of manpower administration activity is carried out at the state and local levels simply because it must be done if the program is to operate.

Recruitment of Manpower

Recruitment of professional and technical workers is conducted by state and local public agencies, universities, voluntary agencies and federal agencies. Much of the recruitment depends on personal contacts, advertisements in journals, and recruiting booths at professional society meetings. There is often sharp competition between programs that would probably have more success if they could find a way to cooperate. There are few research studies or guidelines to aid in recruiting workers. Meanwhile rigid regulations or personnel systems severely restrict recruitment for service delivery programs.

At another level there are occasional programs to recruit young people into mental health careers. Most of these programs offer promise for recruiting rural youth into mental health careers to help meet the need for rural practitioners. However, there is little support for such programs in most places and the approaches tend to be intuitive and experimental with little long-term follow-up.

Distribution of Manpower

Distribution of manpower is an ongoing problem for state and local mental health programs, especially in finding professionals for programs in rural areas, state hospitals and for inner city poverty areas. There are also problems with the distribution of specialists to work with children, adolescents, and the aged. Several states have experiemented with special stipend programs with indenture provisions for the training of professionals to work in these less attractive areas. The results have been variable, but some states, by combining careful selection, stipend support, special training and regular counseling, have improved their situations. We need more systematic attention to the whole matter of manpower distribution -- at present a more serious problem than overall supply.

Utilization of Manpower

No element of mental health manpower concern is as poorly understood or has more potential for increasing the "power" of existing mental health personnel than utilization. There is a tendency to organize and use workers in stereotyped ways. There are many aspects of manpower utilization that deserve attention:

1. The kinds of professional work performed: long-term psychotherapy for a few clients or short-term or group therapy; elaborate routine studies of all clients or a few critically needed studies.

2. The mechanics of working conditions. Time may be wasted on clerical duties or routine but necessary staff meetings; women employees might be employed part-time so they may be with their school-age children in the afternoons.

3. The working relationships between the various professionals and between them and paraprofessional workers. Most programs use "teams," but there are several team models that have different implications for staff efficiency. The medical team requires that everyone be directed by a physician; the routine evaluation team tends to do a full battery of tests and assessments before it convenes for a decision; the "one-workers" or case manager-coordinated team tends to fix responsibility for each client and to be more efficient.

4. The organization of staff. When staff is organized by professional departments, there tend to be turf battles and little acceptance of paraprofessionals. Functional units or geographic unit organizations of staff may provide greater efficiency and stronger goal orientation. Organization of staff will determine what each worker is accountable for -- professional standards, agency efficiency, or client welfare.

5. The organization of staff to clients and services. Are staff assigned to clients to maintain continuity throughout their course of treatment, or assigned to services which then require transfers of clients and some loss of efficiency? Are staff assigned to meet all the needs of certain clients or to functional duties, such as giving medications, escort services, or feeding?

6. The use of paraprofessional workers. Are these workers used at all? If so, do they function as generalist client workers, or as aides to one or another of the specialists. Are they assigned to only specific tasks? How do they relate to other staff and to clients, and are these relationships articulated and understood by all?

Career Systems and Retention of Manpower

In most mental health programs there are no career systems -- except for a few steps within individual job categories. There is no way for low-level employees to make a career in the agency except to terminate employment, go through a formal educational program, and reenter the system. The result is a large amount of staff turnover.

Even within the higher-level workers in the professions, there is a tendency to advance by either leaving the agency and moving to other human service agencies, or by moving into administration or education. Even those professionals who remain in a single agency advance by moving from practice to administration or education with no particular preparation for their new positions.

A few state and local mental health agencies have developed career plans on paper; in most places these have not really been implemented. There are few attempts to deal with the problem of turnover because of the lack of career opportunities. These efforts often involve changing job titles from "professional" to "functional" titles, but this runs counter to many reimbursement plans. The state and local agencies need help in the whole area of career development.

Minority Issues

Mental health agencies have been pressured to open up employment opportunities for ethnic minorities and women. This problem is primarily related to high-level positions and certain professions.

Another problem lies in a shortage of minority persons enrolled in certain professions and although certain efforts have been made to catch up, the agencies are still faced with the problems of recruiting these minority persons and integrating them into their job systems. This is not a problem unique to mental health agencies.

Manpower Training

Manpower training has been the traditional focus of manpower programs, particularly at the federal and state levels. Within the overall rubric of training there are some decided biases and gaps. Primary among the biases is the emphasis on preservice professional training of the "big four" professions, almost to the exclusion of other professions, paraprofessionals, and continuing education.

All areas of training need close ties to the delivery system. There has been a tendency for basic professional education to concentrate on clinical pathology and therapy in teaching hospitals and clinical training centers. Thus, the students are not exposed to the day-to-day realities and pressures of the delivery system. The result is that the students are ill-prepared for an important aspect of their jobs as staff workers, i.e., the daily activities of the delivery system.

Developing Educational Programs

Basic professional education programs are developed by university-based practitioners. Too often this is done with little consultation or input from the service delivery system. Graduates may then be ill-prepared for jobs or jobs may not exist at all. Major problems occur when graduates are trained in role models or with value orientations different from those expected in agencies. The NIMH support pattern has given reinforcement for educational program developers to bypass the delivery system by allowing grant requests to be submitted directly to NIMH with no clearance regarding the need for such workers or the appropriateness of the models being offered by the training programs.

Preservice Professional and Paraprofessional Education

There is need to bring professional education up-to-date with the trends in the delivery system so that the programs can provide leadership and have credibility with the agencies. There is need for closer ties between academia and agencies.

There is also need for experimental programs for the training of new kinds of workers and for new competency-based educational methodologies. Methods to evaluate the effectiveness of training programs, particularly in regard to their impact on clients and service delivery, must also be developed.

Continuing Education Programs

Continuing education will need special attention to make it sensitive to the programs and problems of the agencies. Organizational development approaches, in which the training focus is on problem-solving for each particular agency and group of employees, seem to offer the greatest promise, but little is known about planning, instructing or evaluating such programs.

Funding Education Programs

There are serious questions regarding funding for educational programs. The distribution over the years at both state and federal levels has been heavily biased in favor of preservice training for the major professions.

Policy determination of priority needs must be made. Should more workers be trained? What kinds, paraprofessionals or professionals? Or, should concentration be on upgrading the competence of the existing manpower pool -- especially through continuing education programs -- to improve their skills in programming and administration? Should NIMH directly support training institutions and trainees or should the funds be distributed to the states to let them decide how they want to manage their own manpower development programs?

Sanctions Affecting Mental Health Manpower

In addition to the matters of manpower planning, administration and development, there are other social, economic, legal, and regulatory influences on manpower. These influences are often the primary responsibilities of organizations and jurisdictions, such as licensing boards, funding bodies, legislatures, courts, national accrediting organizations, and federal and state regulating bodies, and are perceived as being outside the scope of manpower concerns. But, they cannot be realistically ignored by persons concerned with manpower.

Usually these organizations are only slightly aware of the influences which their activities have on the mental health manpower situation in the states and localities. Ways must be found to include them in the overall manpower operation at all appropriate levels, to increase their awareness of the manpower implications of their activities, and to modify these actions to improve the total mental health manpower operation.

The major sanctioning influences on mental health manpower are:

Licensure and Certification

States pass and revise licensure laws in their legislatures. The major inputs to this legislation come from the state and national professional associations and to a lesser degree from state mental health agencies. Licensure activities are carried out by individuals or conjoint boards of professional licensure.

Licensure has certain problems:

1. The legal requirements vary considerably in the 50 states and restrict movement of professionals from one state to another.

2. Provisions of licensure laws often restrict various categories of workers in what they are permitted to do.

3. Licensing procedures and record-keeping are often chaotic in the individual states.

4. It is hard to revoke a license or to assure that the licensee retains his competence.

5. Increasingly, continuing education is being required as a condition of relicensure or certification.

6. Renewal of licensure is generally based upon payment of fees only. Peer review of practice is generally viewed as the prerogative of the practitioner at the local level, either through the service agency and/or local professional society.

Standards

Standards are statements of conditions and criteria within which programs are expected to function. They may be applied to mental health programs and facilities for a variety of purposes: a) to assure a minimum level of care, b) licensure, c) accreditation, d) determining differential funding or reimbursement rates, e) as model or ideal goals for programs and staff development, f) recognition and public assurance. Standards may be used as guidelines within agencies or as regulations by licensing or funding bodies.

Although standards may be based on program inputs, program processes or program outcomes, most are either input or process standards. There is a tendency to spell out rigid input standards for staffing (ratios, professional qualifications, etc.) which

can be very restrictive of manpower. It is preferable to have process standards that spell out the procedures and processes rather than the inputs. Efforts need to be made to modify existing standards which are too restrictive, and to develop consistent new standards that assure both flexibility and quality.

Judicial Activities

Until recently there has been little judicial activity related to mental health that concerned manpower. However, during the past five years a flurry of "rights" suits have been filed, usually in federal courts. Sometimes these have been suits regarding patient rights -- right to treatment, right to a less restrictive environment, right to education, etc. At other times these have been suits regarding the rights of employees, minorities or communities.

There is an increasing tendency for these actions to result in court orders directing how many of the various kinds of mental health professionals and technicians shall be employed and how they shall be used in mental health programs. Most specific in this regard have been the cases of Wyatt vs. Stickney in Alabama and the Willowbrook State School order in New York. However, many other judicial decisions and court orders have serious implications for manpower requirements and manpower utilization.

Unions

The past ten years have seen an expansion of unionization in hospitals and other mental health programs. While much union activity is concerned with salaries, fringe benefits, and overall working conditions rather than manpower concerns, there are many aspects of union activity, such as work schedules and assignments, which have major manpower significance. Some unions are now requesting training benefits. There has been little systematic exploration of the best ways to integrate union concerns with public mental health delivery systems so that the programs best serve the clients and, at the same time, protect and enhance the rights and responsibilities of employees.

Legislation

Mental health programs in the public sector are both enabled and constrained by legislative acts of both the U.S. Congress and the individual state legislatures. This includes both the authority for programs to exist and the appropriations for their support.

In general, legislation has tended to be broad and flexible with provisions for greater specificity to be added by administrative guidelines to be written by an executive agency, such as the Department of Health, Education, and Welfare or the state mental health agency. However, in recent years Congress and state legislatures have tended to make legislation more specific in ways that spell out certain manpower requirements or practices. These restrictions may be in authorization bills, appropriation bills or in the regulatory bills, such as licensure acts, workman's compensation bills and malpractice bills.

Regulations and Guidelines

Regulations and guidelines are the specific directives or suggested directions of executive agencies, such as the Department of Health, Education, and Welfare or state mental health agencies, to implement mental health or health legislation. They tend to be quite specific in ways that have serious manpower implications (e.g., regulations that require that community mental health center directors must be Board-certified psychiatrists). There is a tendency for regulations to be strongly influenced by professional groups and, thus, to reflect their interests more than the interests of clients. They are often built upon fixed models or doctrines which are restrictive on the uses of manpower. They almost never require that overall manpower concerns be explictly dealt with.

Payment Patterns

Payment patterns, whether for individual services or for salaried employees, influence the kinds of workers who are used or the work they do. This is true in private practice and private programs as well as in local and state mental health programs. Fee-for-service payments from third party payers often exclude payment for some services or restrict payments to certain kinds of workers. Salary classification for employed workers may be differentially so low or high that they exclude or restrict some kinds of workers or require that certain personnel be wastefully used for tasks that might well be done by other workers.

Status Considerations

Status considerations provide a powerful, but often subtle, influence on manpower matters. They are seldom articulated in such an explicit way as to be overt and easily dealt with. Rather, they

tend to exert their influences through unrecognized values and attitudes, assumptions and social choices. They influence decisions regarding choices of organizational models, treatment models, payment models, and, certainly, which kinds of workers are allowed to carry out which kinds of functions. Status considerations in mental health systems have been particularly influential in impeding the use of paraprofessional workers and in maintaining the hierarchy of the established professions.

Personnel Policies and Practices

All states have operations which manage the formal details of writing job descriptions, developing classifications and pay plans, employing and orienting employees, preparing paper work and payrolls, and administering fringe benefits, pension plans, terminations, etc.

Frequently there is conflict between the officials of the mental health agency and the overall personnel agency. This adversary relationship tends to result in the personnel system, along with the budget office, being perceived as "the enemy" rather than as a service agency to the mental health program. While personnel systems are sometimes rigid and slow-moving, the problems are frequently because the mental health leaders tend to be naive about personnel matters and to be more oriented to professional prerogatives than to good personnel practices.

Personnel policies (i.e., low salary classifications, inadequate fringe benefits) can pose problems for manpower recruitment and retention. Most often the squabbles are the results of attitudes, rigidities, and annoying delays rather than fundamental personnel problems.